			1 - For State Registrar	State of Maryla		partment ertificate				iene	05	15	001
	-: · ·		1. Decedent's Name (First, Middle, La	ist)					2. Date of Death	n Day	Year		ne of Death
	Physicia /Medic		JOHN		wh	EAT	2 F	<u> </u>	AP1212		2004	15	: 53 PM
1	Examin		4a. Facility Name (If not institution, gir			4b. City,	Town, or	Location of Death		4c. Cou	nty of Death		
			Bon Secour					nore If Under 24 Hrs.	T		/ A		
	Funeral Director		-	Sex 7. Ag <i>e (In yi</i>	rs. <i>iast birtno</i> Yrs	Months	Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Cou	intry)	tate or Foreign
			Usual Residence of Decedent	- 01					11-14-	1943	Бал	LULIII	ore,Md
	ylanc Jow		10a. State 10b. County	10c.	City, Town o	Location						10d. Insi	de City Limits
	Mar 6-1 sl	ctor	Md. N/A		Balt	imore						¹ X	Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip	Code		10	Og. Citizen	of What Cou	intry?	
	ath w		2527 McHenry	Street.		21	223			USA			
	filed within 72 hours after death with the Maryland Hygiene. other then "netural", or Items 23a or 28e-1 show ent, the Medical Examiner must be multified at	Funeral	11. Marital Slatus	12. Was Decedent Ever in Armed Forces?	U.S. 1	Was Deced If Yes, spec	ent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White		an,
30	s afte	by F	1 ☐ Nøver Marriød 2 X Marriød 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 43	15	1 ☐ Yes	No.	Specify:		Spe	ocity: B1	ack	
3	hour	edt	15. Decedent's E			ecedent's Usua	I Occupa	ation		16b Kind of	f Business/le		
	in 72 n "ne	Completed	(Specify only highest gi	ade completed)				turing most of word Transf				,	
Maryland 21215-0036	d with giene or the	mo	12	College (1-4or 5+)	Ba1	timor	e-P:	ittsbur	gh	Truc	k Dri	ver	
2	othe vent,	Bec	17. Father's Name (First, Middle, Las	;)					e (First, Middle, N	faiden Surr	name)		
<u>a</u>	should be and Mental marked o	10 0	John A. Wh	eatley Sr.				Fann	ie Wh	eatle	ev		
a	2 sho and I Is me		19a. Informant's Name/Relationship		19b. M	ailing Address	(Street a	and Number or Ru	ral Route Number,	City or Tox	wn, State, Zi	р Code)	
	and ealth m 27 ner tr		Ella Wheatle					ry Stre	et,Balt				
9	Pages 1 nent of H int: If itel		20a. Method of Disposition N Burial 2 □ Cremation 3 I	Removal from State	cemetery,	sposition (Nan crematory or o	ther plac	·		20c. Locatio	on - City or T	own, Sia	at <i>e</i>
Ē	Pag tment tent: jury		4 □ Donation 5 □ Other (Spec	(fy) C	rowns			.Cem 5/	5/05	Crow	nsvil	le,	Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28e-1 show eny injury or other treumatic event, the Medical Evanting must be reciliated at once.		21. Signature of Funeral S. Vio. Lice	nsee D		Esten	d Addres Bro	s of Facility Others	Funeral	Ser	DΔ		
	40 = 0 d		Luy !	sey					Funeral e,Balti		, Md.	212	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each line.								Approx Interva Onset	al Between and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)				CE	PHALO	PATH)	/			1A-75
B	/Medical Examiner		Toodking in dodain,	Due to (or as a cons			0					,	n 0344
		-	Sequentially list conditions,	b. Due to for as a cors	NUE	70N/	1					6	D.475
	ited insit	ulu u	dany, leading to inin-ediate cause. Enter Underlying Cause (Disease or injury	4011	TE	ZEN	91	FAIL	URE			6	DAYS
<u>,</u>	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	1 2) 0 //	,	FAIL		,			
8760,	Attending Physicien: The taw requires that the death certificate be executed in death. If death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dlcal		d ARTER	21030	LERO	710	HEA,	RT DI	SEA	SE	211	12/100
9	tificat ng phy as th	0											
Box	that the death certific ed by the attending p detached for use as	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F		3 ⊟Ectopic pr	eanancy			1	Date of deliv	,	
	deat death	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		5 Other (sp					Month	Day	Year
0.	at the	Phy	9 Unknown										
Ś	ires that signed b	Completed by Physician/M	Part II. Other significant conditions	Contributing to death but not i	resulting in th	e underlying ca	ause give	en in Part I.	23e. Did tob				e of death?
0	w requir been si should	eted			20				1 1 18	s 2 No			
ခ္	has b	nple	CARCIN	DMA OF 1	K63	1 KAT	E		24a. Was ar autops	24	b. Were aut prior to co	opsy find ompletion	lings available n of cause of
<u></u>	cate pag		HYPOT	HYROIDIS.	279				perform 1 Yes 2	No No	death? 1 ☐ Yes	2 N O	>
\frac{12}{5}	icien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			A Oth	or	th (Check only one				
Division of Vital Records,	Physicien: The tartificate har tal director, page 2	. To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	28b. Tim	e of 2	8c. Injury	4 140131119 11	ome 5 ☐ Reside 28d. Describe ho			rfy)	
o	ding h. After fune	tlon	1 KNatural 5 ☐ Pending	(Month, Day Year) Inju		Worl	k? Yes 2 □ No	200. 20001120 110	m injury oo	001100		
S	Atten deat ctor; y the	fica	3 ☐ Suicide 6 ☐ Could not	be 29a Place of Injury A	t home, farm				28f. Location (Str	reet and Nu	imber or Rui	ral Route	Number,
á	al or after	Certification:	4 Homicide	building, etc. (Spe	ecify)	,			City or Town	, State)			
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director; After this completely filled in by the funeral di		29a. Certifier 1 Certifying F	hysician: To the best of my l	knowledge, d	eath occurred	at the tin	ne, date and place	and due to the ca	ıusə(s) and	mannør as	stated.	
	he Ho in 24 he Fu oletel	edical	(Check only 2 Medicel Exe	miner: On the basis of exam and manner stated.	ination and/o	r investigation,	in my o	pinion, death occu	rred at the time, da	ate and plac	ce, and due	to the ca	use(s)
	To the withing To the comp	ž	29b. Signature and title of certifier	211/4/02				e numb <i>e</i> r			ned (Month		
	X			ONIN	NID	•	D	2330	0	APA	A12 :	28	2005
1	7 '		30. Name and address of person who	completed cause of death (I	tem 23a) (Ty	pe, Print)	130	N SE	LONR	5 17	ast.		
-	ł.		SUDMIR, 2		20	10 W.	BA	20 37	conr.	To.	MAD	2)	223
•	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. Registrar's Sig									
8	Tregisti	en l	MAI U 3	/ HILL 1970	N.	Rosell !							

			T = For State Registrar	State of Marylar	nd / Depa <i>Ce</i>	artment of H	ealth and M Death		ene	5 15002
			1. Decedent's Name (First, Middle, Last)		-			2. Date of Death Month		3. Time of Death
	Physici /Medio		EMORY	J.	YODE	R		April		005 3:45 P M
}	Examir		4a. Facility Name (If not institution, give s	treet and number)			Location of Death		4c. County o	of Death
		н	7227 Mennonite Chi	ırch Road		[₩	Westover		Som	erset
	Funeral		Social Security Number 6. Sex	7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		214-36-5771	9	O Yrs.			August 11,		Maryland
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	show	5	Tou. State	100.0	.,, 10 0. 2.	oution				1 ☐ Yes 2 ☑ No
	8a-f	Director	Maryland Somers 10e. Street and Number	et		1.01.71.0	Westove			
	ours after death with the Maryla rel', or Items 23e or 28e-f shov Exeminer must be notified at		10e. Street and Number			10f. Zip Code		10	g. Citizen of W	nat Country?
	s 23c	Funerai	7227 Mennonite Chi		10		21871		44.5	USA
	er de Item	nue		Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
36	saft.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2XXNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐KNo	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f ehow he Madical Extentine must be matified at	pa	15. Decedent's Educ		16a Dece	dent's Usual Occupa	ation		6b. Kind of Bus	singes/Industry
15	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	00.111100.00	
12	withir iene. then	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		Farmer			Farm	ina
	rould be filed within I Mental Hygiene. narked other then natic event, the Ma	BeC	17. Father's Name (First, Middle, Last)			razmez	18. Mother's Name	e (First, Middle, N		
an	id be ental ked o	To B	Daniel P. Yoder				Leah Hei	rshberge	_	
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, I	-	19a, Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address (Street a				State, Zip Code)
M	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. Item 27 is marked other then "netun other traumatic event, tha Madical	0 1	Viola Mae Yoder (V	life)						r, MD 21871
ē,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra <u>once</u> .	1	20a. Method of Disposition		Place of Dispo	osition (Name of		Date 2	20c. Location - C	City or Town, State
Baltimore,	Pages nent of h ant: If its ary or o		1 🖾 Burial 2 □ Cremation 3 □ Ro '4 □ Donation 5 □ Other (Specify)		-	matory or other place	1	× 1/20/15	Mostor	Maren I and
	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License							ver, Maryland
Ba	permit. Departn Importa any inju		1100 Bell X	Show the		2. Name and Address radshaw &				
	_		Mary Beth Brads 23a. Part1. Enter the disease, or compli	Shaw-Pruitt ations that caused the dea						land 21817 Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		,	09990			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)			ASCI	9			
	Examiner			Due to (or as a conse	quence or):					
		F	Sequentially list conditions,	Due to (or as a cons	quence of):					
	uted Insit	in I	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć.	exec n and ial-tra	Examiner	resulting in death) Last	Due to (or as a conse	quence of):					
8760,	cate be executed physician and the burial-transit	dicai								
.89	ificat g phy as th	edi								
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregr		-			23d. Date	of delivery
-	death a atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			Mont	th Day Year
P.0.	at the de by the tached	hys	9 Unknown	9□ Unknown						
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contril	bute to the cause of death?
Vital Records,	quire n sig	d b						1 □ Ye	s 2 No 3	3 ☐ Probably 4 ☐ Unknown
00	w require s been sign should b	Completed						24a. Was an		ere autopsy findings available
Re	The lav	Juc.						autopsy	pr led? de	rior to completion of cause of eath?
ta	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26. Place of Deat			Yes 2 No
	Physician: this certificatal director, I	ToB	examiner?	ospital:] ER/Outpatie	nt 3 DOA Othe		12.4		r (Specific)
of	g Phy er this		27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Injury	at	28d. Describe ho		
lon	th. : Afte	it o	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1□`	c? Yes 2 ☐ No			
Division	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	nome, farm, st	reet, factory, office		28f. Location (Str	eet and Number	r or Rural Route Number,
D	al or	Certification;	4 Homicide determined	building, etc. (Spec	ıry)			City or Town	State)	
	spita nours nere		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, deat	th occurred at the time	ne, date and place,	and due to the ca	use(s) and man	ner as stated.
	To the Hospital or Attending f within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examination)	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my op	oinion, death occur	ed at the time, da	te and place, ar	nd due to the cause(s)
	To the withing To the somp	Me	29b. Signature and title of certifier	1		29c. License	number	29	d. Date signed	(Month, Day, Year)
)	/		· N V	1 40		D	48098		April 2	27, 2005
	6		30. Name and address of person who co	npleted cause of death (Ite	m 23a) (Type.		1			
			Vijay Karumbur	athan M.D.	- 201		way - Cri	sfield.	Marvlar	nd 21817
	Sta	ite	31. Date filed (Month, Day, Year)	32. Jegistrar's Sign	at A	and I	1 023	/		
	Registr		MAY U 3 ZU	UJ WALLE	- 1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0607 AM ZAREMBA **AGNES** MARY **Physician** 4c. County of Death /Medical 4b. City, Town, or Location of Death a. Facility Name (If not institution, give street and number)
UNION MEMORIAL HOSPITAL N/A BALTIMORE **Examiner** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye. 4-4-1915 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 90 Months MARYLAND **Funeral** 1 ☐ M 2 🖾 F 215-18-3073 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State 1 ☐ Yes 2 ☐ No 77 Is marked other then "natural", or items 23e or 28a-1 show traumatic event, the Medical Examiner must be natified at WESTMINSTER CARROLL MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21158 3000 Mayberry Road 14. Race - American Indian, Black, White, etc. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Specify. Baltimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TATIOR and Mental Hygiene. Is marked other then **SEAMSTRESS** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KATHERINE (SEMSKI) JOHN CHARLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WESTMINSTER, MD 3000 MAYBERRY ROAD permit. Pages 1 and 2::
Department of Health ar Importent; If item 27 Is any injury or other trat JOHN T. ZAREMBA/ SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) BALTIMORE, MD 5-5-05 Gardens of Faith Cem! 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Euneral Service Licensee ROSEDALE, MD 21237 1211 CHESACO AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** sequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ro the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: Day Month Year 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Ö 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P. Completed by 3 Probably 4 □Unknown 2 No 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy 27 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Ampatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death the funeral After 1-ANatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 4 Homicide completely filled in by 11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a To the Funeral L 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific tame and address of person who completed cause of death (Item 17 31. Date filed (Month Day) State 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 28, 2005 2:35 A Feroza Abdul-Hagg April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel North Arundel Hospital Glen Burnie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director Dec. 17,1924 India 140-34-3056 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location **ehow** 10a. State 10b. County other traumatic event, the Medical Examiner russ be notified at 1 XYes 2 No Director Maryland Anne Arundel Odenton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 2013 Bunkerhill Court 21113 United States or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 Married Asian-Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Psychologist State Government-Ohio 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be if Health and Mental item 27 Is marked o Abdul Inayad Bibi Kahn Hagg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2013 Bunkerhill Court Odenton, Maryland 21113
of Disposition (Name of Date 20c. Location - City or Town, State Asghar A. Haqq/Brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of I Nichols-Bethel United 1 XBurial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 4/30/2005 Odenton, Maryland Methodist Cemetery 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Thomas xianito M00957 1411 Annapolis Road Odenton, Maryland 21113 Approximate Interval Between Onset and Death 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician <u>Congestive Heart Failure</u> /Medical Due to (or as a consequence of). Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of). P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached f ☐Yes 27 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an was a.. autopsy performed? Yes 20 No has page certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one)_ Hospital: 1 XInpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Ė this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification; After Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a

To the Funeral I

completely filled the Hospital filled Experience of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and ad person who completed cause of death (Item 23a) (Type, Print) Burne State Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registramend item #31 per dvr g843 5704/f03/tanof Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** P M APRIL 29 LOUIS 2005 4:56 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS - BAY VIEW BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT.5,1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 82 Director 054-18-3014 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ir than "natural", or items 23s or 28e-1 show the Medical Examiner must be nutified at 1 ¥Yes 2 ☐ No Director BALTIMORE N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 2901 BOSTON STREET #315 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No ARMY If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LAW ATTORNEY 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental sht: if item 27 is marked o ARONIN MARGOLIS **ISADORE** DINAH 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health item 27 2901 BOSTON STREET #315 - BALTIMORE, MD 21224 GERALDINE ARONIN / WIFE other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of importent: if any injury or BALTIMORE HEBREW CEM. 05/02/2005 REISTERSTOWN, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onse and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Myocardia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9□ Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. à 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Vital Hospitei or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3 DOA 1 ☐ Yes 2 No 9 this Division of 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural Accident 5 Pending 1 🗌 Yes 2 No death. investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 24 To the F the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0001486 KOWOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL BALTO, MD. 21224 THOMAS POZEFSY MAY 0 4 2005 Registrar

Am DUR, FriedA

		For State	State of Maryland / D		Health and M	Mental Hyg	giene	15006
		Registrar 1. Decedent's Name (First, Middle, Last)		Jeruncate or	Death	2. Date of Dea		3. Time of Death
Physic		FRIEDA		AMI	DUR	April	30 200°	
/Med Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Town,	or Location of Death	_	4c. County of De	N/A
Funeral		5 Social Security Number 6, Sex	7. Age (In yrs. last birth	nday) If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of Birth	9. B	rthplace (State or Foreign Country)
Director		215-54-3081	1M 2ÅF 87 Y	rs. Months Days	s Hours Min.	10/25/13	917	MD
yland yland		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
e Mar 3a-f st	ctor	MD BALTIM	ORE BALTIN					1 □Yes 27 No
with th	Funeral Director	10e. Street and Number	N DOAD	10f. Zip Code 2120			10g. Citizen of What 0	
Jeath Ins 23	erai	2439 FOREST GREE	12. Was Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cu		pecify Yes or No-		nerican Indian,
Te, INIBLY ISING ZIZIO-UOSO 1 and 2 should be filed within 72 hours after death with the Maryland 1 Health and Mental Hygiene 1 Health and Mental Experiment of the recognitive of the prominer must be a published at	y Fur	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 N No If Yes, Give	1 ☐ Yes 2 N		o Hican, etc.)		HITE
72 hours natural; of the lical Engl	ed by	3 X Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	Decedent's Usual Occ	upation		16b. Kind of Busines	s/Industry
hin 72	piet	(Specify only highest grad	College (1-4or 5+)	(Give kind of work don life. DO NOT use retii	ne durina most of wor			UDITV
ed with ygiene yar the	Completed	Elementary/Secondary (0-12)	ADM	INISTRATOR	40 Markada Nasa		SOCIAL SEC	URITY
aryland 2 should be filled nd Mental Hygi markad othar imatic evant, I	Be	17. Father's Name (First, Middle, Last) ISAAC	1.0	ONDON	FLORA	ne (First, Middle.	Maiden Sumame)	WEINER
Should Me nd Me mark	J.	19a. Informant's Name/Relationship (T)		Mailing Address (Stre		ıral Route Numbe	r, City or Town, State	
ore, Ma ss 1 and 2 sl of Health an litem 27 is r other traus		BARBARA ROSENBAL		804 SEVEN	MILE LANE		ORE, MD 21	
ages 1: nt of He I: If Iten		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	Removal from State ANSHE			2/2005	BALTIMORE	
Baltimore permit. Pages 1 Department of H Important: If Ite any injury or ot page.	á	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	18114	CHAIM) 22. Name and Add			SON & BROS	
Depariment of the policy of th	Ž .	Robert 10	f	8900 REI	STERSTOWN	ROAD -	PIKESVILLE	, MD 21208
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death. Do n ne cause on each line.	ot enter the mode of d	lying, such as cardiad	or respiratory are	rest,	Approximate Interval Between Onset and Death
Physician /Medica		Immediate Cause (Final disease or condition resulting in death)	a. InTraceR Due to (or as a consequence of		Bleed			
Examine			Due to (or as a consequence o	<i>,</i> , , , , , , , , , , , , , , , , , ,				
/ pg tig	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):				
FbU, e be executed rsician and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of	of):				
/ 6U te be e ysician ne buria	70		d					
C 68 ertificat ing phy e as th	Medi	IF FEMALE:	20. 11					
BOX 68 / Jeath certificate attending physical for use as the	Physician/Medic	in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			23d. Date of o	Day Year
at the d	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown					
	þ	Part II. Other significant conditions co		the underlying cause	given in Part I.	23e. Did to	L c	to the cause of death? Probably 4 Unknown
cord: w require been si	eted	11 4 be levens		·		24a. Was		autopsy findings available
Heck	Completed					autop	rmed? prior to death	o completion of cause of
	Be C	25. Was case referred to medical			26. Place of Dea	ath (Check only o		
of V hyaic this ce al direc	ို	1 Tes 2 Tono		tpatient 3 DUA			dence 6 Other (Sp	pecify)
on o	tion:	27. Manner of Death 1			vork? □ Yes 2 □ No	280. Describe I	low injury occurred	
Division of Vital Records, To the Hospital or Attanding Phyaician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, offic	28	28f. Location (5 City or Tow	Street and Number or vn, State)	Rural Route Number,
Dital or urs after real Dia Hed in								
To the Hospital within 24 hours a To tha Funaral I completely filled	edicai	29a. Certifier (Check only one) NC Certifying Phy one)	sicien: To the best of my knowledge iner: On the basis of examination and and manner stated.	 death occurred at the d/or investigation, in m 	e time, date and place by opinion, death occu	e, and due to the durred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the within To the	₩.	29b. Signature and title of sertifier	1	29c. Lice	ense number		29d. Date signed (Mo	
./		med 8/P	hysician	Doc	328750		April	30,2005
V)	30. Name and address of person who d	ompleted cause of death (Item 23a) (Xe, Th. M.) 24c 32. egistrar's Signatus	(Type, Print)	edeno Au	Ce ANI	tmoro. N	021215
S	State	31. Date filed (Month, Day, Year)	32. egistrar's Signaturo	Locales	Carke III	· C · DA (111 2000 110	- (- (-
Regis	strar	MAY 0 4 2	005 Blower St.	1				

			- FOI	partment of Health and Ment	tal Hygien	e
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Pertificate of Death	Reg. Ne	3. Time of Death
	Physici /Medic		Malbert Brown		Month 30	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City Town, or Location of Death	40	c. County of Death
13	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay) If Under 1 Year If Under 24 Hrs. 8. D	ate of Birth Month, Day, Year	9. Birthplace (State or Foreign
	Director	0	010-48-2574 1XM 2□F 58 Yrs Osual Residence of Decedent		1-22-	46 Maryland
	aryland show	_	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits 1 ★Yes 2 □ No
	ours after death with the Maryland rel', or Itams 23a or 28a-f show Esaminer must be notified at	Funeral Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	s 23a o	ral D	3718 Keene Avenue	21206	(ISA
9	after de or Itams	Fune	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give	3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar 1 Yes 2 No Specify:	Yes or No- n, etc.)	14. Race/Ambrican Indian, Black, White, etc.
5-0036	72 hours after "naturel", or Ita	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	acedent's Usual Occupation	16b.	Specify Black Kind of Business/Industry
1215	within 72 ene. then "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+)	ive kind of work done during most of working e. DO NOT use retired)	Λ	0
N	filed w Hygier othar th	Be Cor	17. Father's Name (First, Middle, Last)	18. Nother's Name (Firs	st, Middle, Maide	RIOMARIC n Sumame)
Maryland	2 should be filled within and Mental Hygiene. Is marked othar then aumatic event, Lie Ms	To B	Malbert Brown SR.	Grace	e Car	npbell
Mar	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 Is marked othar then "natur or other traumatic event, Ite Medical		19a. Informant's Name/Relationship (Type, Print) 19b. M. 19b. M.	ailing Address (Street and Number or Rural Roll	ute Number City	or Town, State, Zip Code)
ore,	ges 1 and 2 t of Health If item 27 or other tra		1 ☐ Burial 2 Cremation 3 ☐ Removal from State	sposition (Name of Date crematory or other place)	20c. L	ocation - City or Town, State
Baltimore,	Pa men ent:		' 4 □ Donation ' 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	our A remoter 5/4	103 15	altimore, MD
B	permit. Departi Import any inj		Van W. Sut	4995 york fd	Bal	12. MID 21212
			23a. Part f. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on the line. Immediate Cause (Final	enter the mode of dying, such as cardiac or res	piratory arrest,	proximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a	- Miles Miles	34200	,,,,,
	LAMITIME	er	Sequentially list conditions, if any, leading to immediate to to (or as a consequence of):			
	be executed ician and burial-transit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	licate be execu physician and s the burial-tra	dical E	d			
9	ertificate ling physi e as the	Medi	IF FEMALE:			
Вох	requires that the death certific een signed by the attending p nould be detached for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
P.O.	d by the deletached	Phys	9 ☐ Unknown 9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	a undarhing causa gwan in Part I	23e Did tobacco	use contribute to the cause of death?
rds,	w requires that been signed t should be deta	d by		ancer		2 □ No 3 □ Probably 4 ▶ Unknown
eco	aw as b	ompleted			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Records,		e Con	25. Was casa referred to medical	26. Place of Death (Ch.	performed?	death? 1 ☐ Yes 2 🗷 No
of Vi	Physicien: this certific ral director,	To B	examiner? 1 Yes Hospital: 1 Inpatient 25 ER/Outpa	tient 3 DOA Other: 4 Nursing Home	5 Residence	
on c	fing After fune	tlon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		Describe how inju	ury occurred
Division	or Attendii ter death. irector: A n by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	ocation (Street a	nd Number or Rural Route Number, e)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	al Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place, and c	due to the cause(s	s) and manner as stated.
	the Ho hin 24 I the Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/o and manner stated.			
	of With	_	29b. Signature and title of certifier	D3 8956	Api	1./30,2005
\	9		30. Name and address of person who completed cause of death (Item 23a) (Ty)	29c. License number D3 8956 pe, Print) Loch Raven, I	Bultin	ne MD 2/239
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	M franks	-	-
do	Regist	ar	MAY 0 4 2005 Blace	C. Lynn		

		•	State of Maryland / D	Department of Certificate			ınd M		jiene	05		A 8
			Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of D	eath
	Physicia		Ella Kate Boughan)				Month April	,	2005	10:30A	М
>	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, To	own, or l	Location of	f Death		4c. Cour	ity of Death	h	
			St. Agnes Healthcare	Balt			SA LLas T			1		
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birt 100		Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	, Year)	Col	hplace (State or untry)	Foreign
	Director		218-32-2072 100 Usual Residence of Decedent	110.	1			Nov. 26	,1904	Vir	ginia	
	vland ow		10a. State 10b. County 10c. City, Town	n or Location							10d. Inside City	Limits
	Mar	tor	Maryland Baltimore C	atonsvill	le						1 🗌 Yes	2≹ No
	or 28.	Director	10e. Street and Number	10f. Zip C	Code			1	l0g. Citizen o	f What Co	untry?	
	23a	rai	313 Chalfonte Drive		2122					.S.A.		
96	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Important; if item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Evantical must be notified at ance.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Deceder If Yes, specify 1 ☐ Yes 228		spanic Orig i, Mexican Specify:	jin? (Spe , Puerto	cify Yes or No- Rican, etc.)		lack, White	rican Indian, e, etc. hite	
8	2 hours	edi	15. Decedent's Education 16a.	Decedent's Usual (Occupa	tion			16b. Kind of			
212	nin 72 in "na Madi	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Gîve kind of work life. DO NOT use			of worki	ng				
21215-0036	d with giene er the	Completed	12	C1	lerk				Post	Offic	е	
nd	al Hy d oth	Be	17. Father's Name (First, Middle, Last)					(First, Middle,	Maiden Sum	ıme)		
Maryland	Meni Meni arke	မ	Robert Mitchell			<u>-</u>		ırston				
Nar	12 sh and is m			. Mailing Address (S					•			
e,	1 and Health em 27 ther t		20a Method of Disposition 20b. Place of	3 Chalfor	g of	1	-	LOIISVII. ate	20c. Location	_		
Jou	ages nt of t; if it		1 X Buriat 2 Cremation 3 Removal from State	ry, crematory`or othe n Park Cei	-		4-29	-2005			Marylan	ıd
Baltimore,	artme artme ortan injury		' 4 □ Donation 5 □ Other (Specify) LOUGOT 21. Signature of Funeral Service Licenses	22. Name and	Address	s of Facility	V					
Ba	Depa Impo any ir		(Semantalnesses)	Witzke E 1630 Edm	Fune	ral F	Home	of Cato	onsvil.	le, I Marv	nc.	228
	Physician		23a. Part1. Enter the disease, or omplications that caused the death. Do r shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	not enter the mode						Hary	Approximate Interval Betw Onset and De	een
	/Medical Examiner		resulting in death) Due to (or as a consequence of	of):								
Ы		<u></u>	Sequentially list conditions, b. Due to (or as a consequence or	of):								(in
	nted Insit	i i	cause. Enter Underlying Cause, Clescass or Film.	<i>'</i>								
Ć,	execting and saletra	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of	of):								
8760,	cate be executed physician and the burial-transit	dicai	d.									
9	rtifica ng ph	Med	IF FEMALE:						1			
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic preg 5 □ Other (spec						Date of deli Month	,	ear .
σ	s that the ned by th e detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cau	use give	n in Part I.		23e. Did to	bacco use co	ntribute to	the cause of de	ath?
rds	w requires that been signed I should be det	ed b	Diabetes Mellitus					1 🗆 Y	es 2 3 100	3 ☐ Pro	obably 4 🗆 Ur	iknown
of Vital Record	e ta has	Completed						24a. Was a autop perfor	sv	prior to death?	itopsy findings a completion of car	vailable use of
ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?			26. Place	of Death	Check only or	ne)			
Ž V	00 W =	2	1 Yes 2 No Hospital: Inpatient 2 ER/Ou			4 L Nu	_	me 5 Resid			cify)	
	ing P	ion:	Natural 5 Pending (Month, Day Year)		c. Injury Work			28d. Describe h	ow injury occ	urred		
sic	Attending Phy r death. ector: Atter thi by the funeral or	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	M street factory		′es 2⊡i	-	28f Location (S	treet and Nu	mber or Ri	ıral Route Numb	ner .
Division	in Dirt	Certification;	4 Homicide determined building, etc. (Specify)	ann, street, ractory, t	01100			City or Tow				
	To the Hospital or At within 24 hours after d To the Funeral Direct completely tilled in by	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge (Check only one) American Examiner: On the basis of examination an and manner stated.	a, death occurred at id/or investigation, in	t the tim in my op	e, date and inion, deal	d place, th occurr	and due to the d ed at the time, o	ause(s) and late and plac	manner as e, and due	stated. to the cause(s)	
	To the To the Complex	Me	29b. Signature and title of certifier	29c.	License	number		2	29d. Date sig	ned (Month	h, Day, Year)	
}	210	1	> My Cu	ī	22	071	7		513	105		
	7/		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	-, A			0 1	1	D •		
	Y		Covergory Levilles 1170	> N. No	VIV.	19	CO	1500	NM	7) >	1228	
	Sta Regista		30. Name and address of person who completed cause of death (Item 23a) of the completed cause of the completed	barle	,)						
	riegist	-11	MATU & LUUJ GERLUE JA	17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item#28e-f. perMF G843, 7/4/05 II
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Month Dav Vaar **Physician** 1:50 P M APRIL 30 2005 GRACE BONTEMPI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHREST HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F TUNISA Director 82 JAN 12, 1923 192.24.4725 Usual Residence of Decedent the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 le marked other than "natural", or Items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 1 Yes 2 No by Funeral Director MD HOWARD COLUMBIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20144 USA 6336 CEDAR LANE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural; or item any injury or other treumetic event, the Medical Examinat once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No XX Specify: Specify: 3√Vidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GIOVANNA MALLIA ANTONIO SAMMITO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6068 WILD GINGER CT COLUMBIA, MD 20144 NANCY BONTEMPI-DORIA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Buriai 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5.2005 MEMORIAL SHRINE CARVERTON, PA 21. Signatur of Funeral Service License 22. Name and Address of Facility FINK FUNERAL HOME, P.A. GREGORY **FUNK** MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Inter the dilease, or complications that caused the death. Do not enter shock, or neart failure ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) With Physician wee KS Cord injury Pina /Medical tue to (or as a consequence of): **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760 attending physician Iclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown multipole myeloma Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ₩No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Residence 6 | Nursing Home 5 | Nursing Home 6 | Nursing H 1 Fes 2 □ No 2 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No Fall April 8 2005 Un Known 2 Accident To the Hospitel or Attend within 24 hours after death To the Funerel Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide assisted living facility Ctr. 6336 Cedar Lane Columbia MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 APril 30 2005 D 006 1199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21204 Jason Black Charlesst North 6601 Touson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 4 2005 Registrar

DHMH 17 Rev 1/2001

Pontempij Grac

4/30/05 150pm

			1 _ For State	State of Marylar				ental Hy	giene	0 17	1 50 0 1 0
			Registrar 1. Decedent's Name (First, Middle, I	act)	Cer	tificate of De		2. Date of De	Reg. No.	U.D.	3. Time of Death
	Physi /Med		Lizzie	В.		Boyd		Month	Day 1	X ^{Year} 5	2:15PM
	Exam	iner	4a. Fecility Name (If not institution, g			4b. City, Town, or Lo	cation of Death	/	4c. Count	y of Death	
	Funera Directo	-	Levindale Nur 5. Social Security Number 217-38-9728	Sex 7. Age (In yrs. 1 M 2 XF 67	last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	th ly, Year) 7 37	Coun	ace (State or Foreign try)
	P.		Usual Residence of Decedent	10-0							
	arylar	٦	10a. State 10b. County		ity, Town or Lo					18	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	Director	MD Baltim	ore	Pikes	ville 10f. Zip Code			10a Citizan et	Mhat Caus	
U	with a or								10g. Citizen of		
17	death ms 23	Funeral	8 Lydia Ct.	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	/as Decedent of Hispa Yes, specify Cuban, M		ify Yes or No	- 14. Ra	S.A.	an Indian,
121	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Exactination and the collined at	à	3 Widowed 4 □ Divorced				Mexican, Puerto R Specify:	ican, etc.)	Speci	ick, White, $_{ ilde{t}}^{ ilde{t}}$: B $1_{ ilde{c}}$	
7	5-0 72 ho	eted	15. Decedent's (Specify only highest of	Education trade completed)	16a. Deced	ent's Usual Occupation	n ing most of workin	a	16b. Kind of E	Business/Ind	ustry
-	Man ne	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ind of work done durin O NOT use retired)					
3	and 21 be filed wintal Hygien od other the			na	1	Jursing A	SSISTAI . Mother's Name				Home
3	Maryland 2121 d 2 should be filed within th and Mental Hygiene. TIs marked other than traumatic event, Land.	Be		31/					Maider Surra	ille)	
$\tilde{\mathcal{D}}$	aryla should I	2	Joe McClean 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailine	Address (Street and	etty Mc(er. City or Town	. State, Zip	Code)
	Ma hd 2 s lith ar 27 is	1	Troy & Linwood			dia Ct.,					,
	Fe, s 1 at 1		20a. Method of Disposition	20b. F	Place of Dispos		Da		20c. Location		wn, State
	Baltimore, Maper permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		Marial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Special Control of the Control	Hemoval from State	•	Forest	Vet. 5	/9/05	Owing	s Mil	le. Md
	Balti permit. Departm Importa	i i	21. Signature of Funeral Service Lic	ense	M =	Name and Address o	Facility				is no
	0 99 6	3	Herine	H Stronge	W 43	ROO Wabas	h Ave.	Balti	imore	БМ	21215
			23a. Part. Biter the disease, or co shock, b heart failure. List on	mplications that caused the deat ly one cause on each line.	th. Do not ente	r the mode of dying, s	such as cardiac or	respiratory as	rrest,		Approximate Interval Between
	Physicia		disease or condition	- Metasta	the F	ancrest	be Car	1cer	_	1	Onset and Death
	/Medica Examine	_	resulting in death)	Due to (or as a consec	quence of):						
			Sequentially list conditions,	Due to (or as a conseq	quence of):						
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					- 1	
	68760, ficate be executed physician and is the burial-transit	Exal	resulting in death) Last	Due to (or as a conseq	quence of):						
	68760, flicate be ex physician is the burial	edical		d							
	68 tificat ng phy as th										
	Division of Vital Records, P.O. Box 68760, Hospital or attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)		ue —		ate of deliver	y Day Year
	IS, P	by Pr	Part II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cause given ii	n Part I.	23e. Did to	obacco use con	tribute to the	e cause of death?
	cords w requires been sign should be	pa pa						101	res 2 No	3 🗌 Proba	ibly 4 □Unknown
	Division of Vital Records, P.O. to Attending Physician: The law requires that the darter death. Director: After this certificate has been signed by the Line by the funeral director, page 2 should be detached	Completed						24a. Was	sy	Were autop	sy findings available inpletion of cause of
	of Vital Re Physician: The this certificate ha	Con						perfo 1 ☐ Yes	rmed?	death?	
	Vital Filclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		1	6. Place of Death				
	Of Phys rthis ral di	년: 12:	1 Yes 2/2 No	1 Inpatient 2	ER/Outpatient 28b. Time of	3 DOA	4 Jursing Hom		dence 6 Ott)
	on on iding the	tlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes	2 No		and inquiry documents		
	Divisio pptal or Attendi ours after death. leral Director: A filled in by the to	Certification;	3 Suicide 6 Could not	be 28e. Place of Injury - At h	ome, farm, stre	et, factory, office	28	of. Location (S	Street and Numi	ber or Rural	Route Number,
	Division in the control of the contr	Cert	4 Homicide	building, etc. (Specif	ry)			City or Tox	m, State)		
	Division To the Hospital or Attending Within 24 hours after death To the Funeral Director:	Medical (29a. Certifier (Check only one) Certifying a	Physician: To the best of my known in the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time, obstigation, in my opinion	date and place, ar on, death occurred	d due to the d d at the time,	cause(s) and m date and place,	anner as sta and due to	ited. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	1		29c. License nu	ımber		29d. Date signe	d (Month, E	ay, Year)
	No		MIL	D/12		2559	143		May	2 2	2005
	[0-1		3% ame and address of person who	o concleted cause of death (Item	m 23a) Type, F	rint)	Ball	1/2	W2/2	15	•
	S Regis	tate trar	31. Date filed (Month, Day, Year)	V 0 4 20 hagistrar's Signa	ature	Good					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2005 Year Mary Lois Brandt May 1, 11:45P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Health Care Center Frederick Walkersville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State of Months | Days | Hours | Min. | Feb. 18, 1922 | Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 24 F Yrs. Director 214-20-0469 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir then "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23224 Ridge Road 20876 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home is marked othar 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence S. Standoff Mary A1ma Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Shank - Daughter 8440 Palmer Road, Middletown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens 5/06/05 Frederick, Maryland 21. Signature of Funery | Service Jouensee 22 Name and Address of Facility Olin L. Molesworth P.A., Funeral Home Lovert d 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ceribro vascular **Physician** accide 4 oves /Medical Due to (or as a consequence of): Examiner Cordinascular Liceof Atherosclerite Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated asserts.) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death ☐ Yes 2 No signed by the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 2 00 Be 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA naral Diractor: After the filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier D0031058 May 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10200 Coppermine Road, 21798 Gene Ashe, M.D. Woodsboro, Maryland 31. Date filed (Month, L State Registrar

			For Stete Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of Hertificate of L			iene	05	15012
			Decedent's Name (First, Middle, Last)					2. Date of Death	h Day	Year	3. Time of Death
	Physicia /Medic		John R. Behanna					May 1, 2		of Dooth	9:30 P M
}	Examin	er	4a. Facility Name (If not institution, give st Manor Care-Bethesd			4b. City, Town, or Bethesd:			4c. County		,
	Francis		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Monte	9. Birthpl	ace (State or Foreign
	Funeral Director		179-24-6978	M 2□F	75 Yrs.	Months Days	Hours Min.	(Month, Day, April 1	9, 1930	Penns	ylvania
	p		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10	0d. Inside City Limits
	shov	'n	D.C.								1∑Yes 2□No
	28e-1	rect	10e. Street and Number		Washingt	10f. Zip Code		10	0g. Citizen of	What Coun	try?
	3a or	I D	469 Ridge Street, N	.W., Apt.	1	2000	1	ī	United	State	2S
	death	Funeral Director		2. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		ck, White,	
36	or Ite	y Fu	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give K Year or Dates:	2	1 ☐ Yes 2X No	Specify:		Specif	y Whi	te
Ö	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28e-f show the Medical Examinet must be multhed at	ed by	3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Educ			dent's Usual Occupa	ation		16b. Kind of B	usiness/Inc	lustry
21215-0036	n "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+	(Give	kind of work done of DO NOT use retired	luring most of worl				
212	d with giene ar the	Com	Elementary/Secondary (0-12)	2		rior Desig			Decorat		
nd	be file tal Hy d oth	3e	17. Father's Name (First, Middle, Last)					e (First, Middle, M	Ma <i>iden Su</i> mar	ne)	
yla	Men Marke Matic	^L	Robert Edward Behan		10h Maili	ng Address (Street a	Sara Rol		City or Town	State Zin	Codel
Maryland	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship <i>(Typ</i> Martha B. Singleton			indsor Vie					0000)
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other then "neturel; or litems 23a or 28e-1 show or other traumatic event, II a Marical Examinet must be redifficed at		20a. Method of Disposition		20b. Place of Disponentery cre	osition (Name of	May 9	Date	20c. Location		
E O	Pages ent of nt: If i		1 Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	emoval from State	l Par	matory or other place ge Memoria rk	2005	5 P	Connell ennsyl	vania	
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 It eny injury or other tra		21. Signature of Euneral Service License	1	M01346	2. Name and Addrese thesda-Chethesda. M	s of Facility Rob nevy Chas lary Land	ert A. P se Inc. 20814	umphre 7557 W	y Fun iscon	eral Home/ sin Avenue
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do not en						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Pneumoni							Onset and Death
	/Medical- Examiner		resulting in death)		consequence of):						
	Examine	_	Sequentially list conditions, if any, leading to immediate		cer with I	Metastasis	s to Lun	S		-	
	nsit	nlne	Cause (Disease or injury	Sepsis							
Ć.	execu in and ial-tra	Examln	that initiated events c. resulting in death) Last		consequence of):						
8760,	cate be executed physician and the burial-transit	dical	d	Dementia							
9	artifica ing ph e as th	a)	IF FEMALE:								
Box	leath certific attending p I for use as	Physician/M	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of delive onth	Day Year
Ö	by the	yslo	1 Yes 2 No 9 Unknown	9□ Unknown							
s, P	es thg gned be de	by	Part II. Other significent conditions con	tributing to death bu	at not resulting in the	underlying cause give	en in Part I.				ne cause of death? hably 4 X Unknown
Record	w requir been si should	Completed						24a. Was a		Were auto	psy findings available
Re	The law cate has page 2	ошр						autops perform	med? 2 X No	death?	mptetion of cause of 2□ No
Vital		(a)	25. Was case referred to medical				26. Place of Dea	ith (Check anly an			
of V	ysic is ce direc	ToB	examiner? 1 ☐ Yes 2X No	ospital: 1 Inpatie	nt 2 ER/Outpatie			ome 5 Reside			1)
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	ow injury occu	rred	
Division	Attendii death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	ıry - At home, farm, s		162 5 140	28f. Location (Si	treet and Num	ber or Rura	il Route Number,
Di≤	after Direction by	Certification;	4 ☐ Homicide determined	building, etc				City or Town			
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the fune	Medical C	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examir	sicien: To the best of ner: On the basis of and manner sta	of my knowledge, dea examination and/or i	th occurred at the tin nvestigation, in my o	ne, date and place pinion, death occu	, and due to the c irred at the time, d	ause(s) and m late and place,	anner as s , and due to	ated. the cause(s)
	ro the within.	Me	29b. Signature and title of certifier	1.P		29c. Licens			29d. Date sign	Month.	Day, Year)
			/ aut	Volve	M. L	1. D	. 202	74	5/	2/0	55
	104	2	30. Name and address of person who co							1	
	1 /		Kirti Vohra, M.D., 31. Date filed (Month, Day, Year)					817			
	St Regist	ate rar	MAY 0	4 2005	s Signature	Spelle					

/Medic	an	1. Decedent's Name (First, Middle, L	th						2. Date of De	Day	2005	3. Time of Death 6540 A
Examin		4a. Facility Name (If not institution, g				4b. City, Town, o					ounty of Death	
		North Aluni		Age (In yrs. I	last hinth day	Glen B			0 Data of Di-		ARU.	
uneral rector		5. Social Security Number 6. 216 18 6158	. Sex 7. A 1 □ M 2 ☐ F	87	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da	20779	9. Birthp Coun Mar	lace (State or Fore try) yland
		Usual Residence of Decedent		10- 01-	~							
Is marked other than "naturel", or items 23a or 28a-1 show eumatic event, the Medical Examinat must be notified at	ក	10a, State 10b. County			y, Town or Lo						1	0d. Inside City Lin 1 🗚 Yes 2 🗆
28a-1	Directo	Maryland N/A		1	Baltim	Ore				10g. Citizer	n of What Coun	itry?
ST De	a D	1153 Nanticok	ke Street			21	.230			U	.S.	•
SE MI	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	S. 13.	Was Decedent of I	Hispanic Ori an, Mexicar	igin? (Spe	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
or of	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ XVidowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates			1 ☐ Yes 2 🕱 No	Specify:			Sp	pecify: Whi	te
CalE	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation	A = \$= dei		16b. Kind	of Business/Inc	dustry
Med	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4o	or 5+)		kind of work done DO NOT use retire	auring mos nd)	it of works	ng	0	17	
nt, Ebe	Cor	6th 17. Father's Name (First, Middle, Las	ot)		Hom	emaker	19 Moth	or's Nome	e (First, Middle,		Home	
c ever	o Be		John Lee Co	ockre1	.1		TO. MOUTE		rude Se		mame)	
ortant: If Item 27 Is marke Injury or other treumatic 8.	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Numbe	er or Rura	al Route Numbe	er, City or To	own, State, Zip	Code)
other tre		Barbara Smith	/ Daughter		100.500	Matthews	Avenu			ore, M	lary1and	1 21225
r iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ € remation 3	☐Removal from Stat	te C	emetery, crei	osition (Name of matory or other pla	-		Date		tion - City or To	
jury		`4 Donation 5 Other (Spec	cify)	Ba		Cremator			/2005		imore, Servic	Marylan
Important: If any Injury o once.		21. Signature of Funeral Service Lic	Programme Consee			2. Name and Addre 4001 Rito		,				
		23a. Part1. Enter the disease, or co	7 0000	any	211				-			
		chock or heart failure. List on	omplications that caus	ed the death	n. Do not ent	ter the mode of dyi	ng, such as	cardiac o	or respiratory a	rrest,		Approximate
ician		šhock, or heart failure. List on Immediate Cause (Final	ly one cause on each	line.		ter the mode of dyi	ng, such as	cardiac o	or respiratory a	rrest,		Interval Betwee
dical		šhock, or heart failure. List on	a Due to (or a	o line. DSEP as a consequ	SiS uence of):					rrest,		Interval Betwee
dical	ər	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a Chroi	DSEP as a consequ nic Ob	SiS uence of): Ostruci	ter the mode of dyi				rrest,		Interval Betwee
edical miner	miner	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to fine cause. Enter Underlying Cause (Disease or injury	a Chroi	o line. DSEP as a consequ	SiS uence of): Ostruci					rrest,		Interval Between
dical niner	Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a	DSEP as a consequ nic Ob	SiS uence of): Dstruct uence of):					rrest,		Interval Between
nysicien and he burial-transit	dicai	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, backing to Extracolate cause. Enter Underlying Cause (Disease or injury that initiated events	a	as a consequence of the conseque	SiS uence of): Dstruct uence of):			Dis		rrest,		Interval Between
nysicien and he burial-transit	dicai	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to first ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:	a	as a consequence of a c	Si Suence of): DStruct Dence of):		onary	Dis		e	Date of delive	Interval Betweer Onset and Deat
dical as the burial-transit	dicai	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, beauing to time ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a	as a consequence of pregna 2 Fetal at time of de	Si Supence of): Distruction of the control of the		wowa-	Dis		e	I. Date of delive Month	Interval Between
oy the ettending physicien and ached for use as the burial-transit ached for use as the burial-transit	dicai	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, beauing to thirt collars cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	as a consequence of pregna 2 Fetal at time of de	Si Suence of): DStruct uence of): Jine incy death 3[eath 5[Ectopic pregnanc	wowa.	Dis	ease	2 3d	Month	Interval Between Onset and Deat
gned by the ettending physicien and properties to be detached for use as the burial-transit and the properties of the pr	by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, backing to finite clians cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a	as a consequence of pregna 2 Fetal at time of de	Si Suence of): DStruct uence of): Jine incy death 3[eath 5[Ectopic pregnanc	wowa.	Dis	ease '>-ns	23d	Month	nterval Betwee Onset and Deat
gned by the ettending physicien and properties to be detached for use as the burial-transit and the properties of the pr	by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, beauing to thirt collars cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	as a consequence of pregna 2 Fetal at time of de	Si Suence of): DStruct uence of): Jine incy death 3[eath 5[Ectopic pregnanc	wowa.	Dis	23e. Did to	23d obacco use Yes 2×1	Month contribute to th	ry Day Year e cause of death
dine is should be detached for use as the burial-transit	by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, beauing to thirt collars cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	as a consequence of pregna 2 Fetal at time of de	Si Suence of): DStruct uence of): Jine incy death 3[eath 5[Ectopic pregnanc	wowa.	Dis	23e. Did to	obacco use Yes 2 1	Month contribute to the Source of S	ry Day Year e cause of death ably 4 Unkr
ite has been signed by the ettending physicien and cage 2 should be detached for use as the burial-transit cage 2 should be detached for use as the burial-transit cage.	e Completed by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, beauing to thirt collars cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	as a consequence of pregna 2 Fetal at time of de	Si Suence of): DStruct uence of): Jine incy death 3[eath 5[Ectopic pregnanc	y ven in Part I.	Dis	23e. Did to 1 24a. Was autoperfo	obacco use Yes 2 N an 2 yrmed?	Month contribute to the solution of the solut	ry Day Year e cause of death ably 4 Unkn
ite has been signed by the ettending physicien and cage 2 should be detached for use as the burial-transit cage 2 should be detached for use as the burial-transit cage.	o Be Completed by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, backing to fine client cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	a	as a consequence of pregna 2 Fetal at time of de	Si Suence of): DStruct uence of): Jine incy death 3[eath 5[Ectopic pregnanc Other (specify)	y ven in Part I.	Dis	23e. Did to	obacco use Yes 2 N an ssy rmed? No	Month contribute to the Source of S	ny Year e cause of death abiy 4 Unkn by findings avail npletion of cause 2 No
oage 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, backing to fine climate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death	a	as a consequence of pregna 2 Fetal at time of definition to the consequence of the conseq	sis uence of): DStruct uence of): uence of): incy I death 3 [eath 5 [Ectopic pregnance Other (specify)	y 26. Place ner: 4 \(\text{Nu} \) ry at	Dis	23e. Did to	obacco use Yes 2 N an sy rmed? No one) dence 6	contribute to the solution of	ny Day Year e cause of death abiy 4 □Unkr Dey findings avain npletion of cause
are mas been signed by the ellerhang physicien and cage 2 should be detached for use as the burial-transit and cage 2.	To Be Completed by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, backing to finite clians cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	as a consequence of pregna 2 Fetal at time of de but not resultient 2 Injury Day Year)	sis uence of): DStruct uence of): uence of): incy death 3[eath 5[ulting in the u	Ectopic pregnanc Other (specify) Inderlying cause grant 28c. Injury Mo M 1	y ven in Part I. 26. Place	Dis	23e. Did to 1 24a. Was autop perfo 1 Yes 1 (Check only o	obacco use Yes 2 N an 2 ssy irmed? 2 No one) dence 6 — now injury of	Month contribute to the second of the secon	ny Year e cause of death ably 4 Unkn osy findings avai npletion of cause 2 No
are has been signed by the ettending physicien and cage 2 should be detached for use as the burial-transit and cage 2.	To Be Completed by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farry, backing to firm ediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	as a consequence of pregna 2 Fetal at time of de but not resultient 2 Injury Day Year)	sis uence of): DSTruct uence of): uence of): uence of): uence of): ER/Outpatier 28b. Time o Injury	Ectopic pregnance Other (specify)	y 26. Place ner: 4 \(\text{Nu} \) ry at	Dis	23e. Did to 1 24a. Was autop perfo 1 Yes 1 (Check only o	23d obacco use Yes 2 N an ssy rmed? No one) dence 6 [now injury or Street and N	Month contribute to the second of the secon	ny Year e cause of death ably 4 Unkn osy findings avail npletion of cause
ite has been signed by the ettending physicien and cage 2 should be detached for use as the burial-transit cage 2 should be detached for use as the burial-transit cage.	Certification: To Be Completed by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, backing to fine cliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	as a consequence of pregna 2 Fetal at time of de but not resultient 2 liquing Pay Year)	sis uence of): DStruct uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatier 28b. Time of Injury wiedge, deati	Ectopic pregnanc Other (specify) Inderlying cause grant 28c. Inju Wo M 1 Teet, factory, office	y ven in Part I. 26. Place her: 4 Nury at rk? Yes 2	Dis	23e. Did to 1 Yes 1 Check only of the Service of City or Toward due to the earth of the service	obacco use Yes 2 N an 2 sy irmed? No one) dence 6 C now injury or Street and N wn, State)	Month contribute to the state of the state	ry Pay Pear Conset and Death Pear Pear Pear Pear Pear Pear Pear Pear
ate has been signed by the ettending physicien and in page 2 should be detached for use as the buriat-transit in page 2.	edical Certification; To Be Completed by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, bearing to finite diata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 20 Medical Examiner) Certifying I could not determine	a	as a consequence of pregna 2 Fetal at time of dea a	sis uence of): DStruct uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatier 28b. Time of Injury wiedge, deati	Ectopic pregnance Other (specify) Int 3 DOA Other (specify) Int 3 DO	y 26. Place ner: 4 Nu ry at rk? Yes 2 me, date an opinion, dea	Dis	23e. Did to 1 24a. Was autop perfor 1 Yes 1 (Check only of City or Town and due to the ed at the time,	an sy long of the state of the	Month contribute to the contribute to contribute to the contribut	ny Year Onset and Death ny Year e cause of death ably 4 Unknowsy findings avail inpletion of cause 2 No 1 Route Number, ated. the cause(s)
After this certificate has been signed by the ettending fr funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	Shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, backing to finite class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	as a consequence of pregna 2 Fetal at time of dea a	sis uence of): DStruct uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatier 28b. Time of Injury wiedge, deati	Ectopic pregnance Other (specify) Int 3 DOA Other (specify) Int 3 DOA off 28c. Injury Wo M 1 Interest, factory, office the occurred at the tit vestigation, in my control of the state of the s	y 26. Place ner: 4 Nu ry at rk? Yes 2 me, date an opinion, dea	Dis of Death ursing Hor	23e. Did to 1 24a. Was autop perfor 1 Yes 1 (Check only of City or Town and due to the ed at the time,	an sy long of the state of the	Month contribute to the second of the contribute to the second of the s	ny Year Onset and Death ny Year e cause of death ably 4 Unknowsy findings avail npletion of cause 2 No 1 Route Number, ated. the cause(s)

				For State Ragistrar		State of	Maryland		irtment of I tificate of	Health and M Death		giene Rag. No.	05	15014
		Physicia		1. Decedent's Name (F	irst, Middle, L	Herman	Edward	Behr	е		2. Date of De	ath Day	2 OOS	3. Time of Death
		/Medic Examin		4a. Facility Name (If no	t institution, g	ive street and numi	ber)			or Location of Death		4c. Co	unty of Death	
				5/59 GRES	EN BRIL		. Age (In yrs. lasi	hirthday)	If Under 1 Year		8. Date of Bir			lace (State or Foreign
	r	Funeral Director		116-16-0733		12 M 2□F	. Age (III yrs. Iasi 83	Yrs.	Months Days	Hours Min.	(Month, Da	ıy, Year)	Coun	Idaho
		and w.		Usual Residence of De	ocedent Ob. County		10c. City, T	own or Lo	cation					0d. Inside City Limits
		the Maryland r 28a-f show notitied at	tor	Maryland	F	loward				Dayton				1 □ Yes 2 No
		with the	Funeral Director	10e. Street and Numbe					10f. Zip Code	21036		10g. Citizen	of What Cour	•
		death w	eral	5159 Green	Bridge Ro	12. Was Deced	ent Ever in U.S.	13. \	Vas Decedent of	Hispanic Origin? (St	pecify Yes or No) - 14.	Race - Americ	an Indian,
	36	or its	by Fun	1 Never Married	2 Married	If Yes, Give	X No		Yes, specify Cub □ Yes 2 No		Rican, etc.)	i .	Black, White, ecify:	_{etc.} White
	00-	"natural",	ted b	15.	. Decedent's	Year or Dat		6a. Deced	lent's Usual Occu	pation		16b. Kind	of Business/Inc	dustry
	215	within 7: ene. than "n	Completed	(Specify of Elementary/Secondary)		grade completed) College (1-4	4or 5+)	life. l	DO NOT use retire		-		Commu	nication
	d 21	be filed w tal Hygier d other tt avent, th	e Cor	17. Father's Name (Firs	st, Middle, La:	1+ st)			Radio C	ommunication 18. Mother's Name		, Maiden Sui	mame)	
	altimore, Maryland 21215-0036	Mental Aental rked o	To Be		C. Ed	lward Behre					Ve	rnice Gr	raybill	
	Aary	2 should and Men and Men is marke		19a. Informant's Name	√Relationship		1		9	t and Number or Ru				Code)
	e, P	1 and Health tam 27 other t		Mr. H. E.)	on 20b. Plac	e of Dispo	sition (Name of	Bridge Rd. Da	Date		ion - City or To	wn, State
	E O	Pages nent of I int: If its iry or o		1 ☐ Burial 2 X C 4 ☐ Donation 5 [☐Removal from Si cify)	ate	-	natory`or other pla remation Se	0.5	/02/2005	S	Sykesville,	Maryland
	Balti	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic avent, ItaM ODG.		21. Sign thus of Funder	al Service Lic	ens			. Name and Addr	ess of Facility Funeral Hom	e, P.A.			
				23a Part 1. Enter the c	disease, or co	emplications that cally one cause on ea	MOO53 Jused the death.	Do not ent	3871 er the mode of dy	Old Columbia ing, such as cardiac	Or respiratory a	tt City, M rrest,	ID 21043	Approximate Interval Between
		/Medical Examiner	iner	Immediate Cause (Fin Isease or condition resulting in death) Sequentially list conditionate. Enter Underlying Cause (Disease or injuit that initiated events	naí	a. C omp on the contract of th		HLS O		ARBIAC I			3	Onset and Death MONTHS
0.1	8760,	rcate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	i,	cDue to (o	r as a consequer	nce of):						
epne	.O. Box 6	Attanding Physicien: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent proving the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?	1 Live bir	ome of pregnancy th 2 Fetal de nt at time of deat wn	ath 3	Ectopic pregnand Other (specify)	ey .		23d.	. Date of delive Month	ery Day Year
S	ds, P	uires that signed to ld be det	d by P	Part II. Other significant AS P(PA		contributing to dea		ng in the u	nderlying cause gi	ven in Part I.		obacco use o Yes 2 □ N		ne cause of death? ably 4 2 Unknown
9	900	aw require as been si 2 should t	Completed	DIABE	ETES	MELLI	TUS				24a. Was		4b. Were auto	psy findings available inpletion of cause of
Š	I Re	sicien: The law certificate has t irector, page 2 s	Com	COROK	ARY	ALTERZY	DIZE	ase			perfo	rmed? 21/2 No	death?	
3	Vita	sicien certifii irector	o Be	25. Was case referred examiner? 1 Tes 2 No		Hospital:	patient 2□EF	VOutpatien	t 3 DOA Ot	26. Place of Dea	th (Check only of ome 5XResi		Othor (Specif	a)
feduan	Division of Vital Record	iding Physith. Ith.: After this funeral dia	-	27. Manner of Death	5 Pending investigat	28a. Date of (Month		Bb. Time of Injury	28c. Inju	4 🗀 Nuising n	28d. Describe			<i>n</i>
	Divisi	pital or Attand ours after death laral Diractor: / filled in by the f	Certification:		6 Could not determine	ad 286. Place o	of Injury - At home g, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (City or To		umber or Rura	I Route Number,
		Hos Pur ely	Medical C	29a. Certifier 1 (Check only 2 one)	Certifying Medical Ex	Physician: To the taminer: On the base	sis of examination	edge, death and/or in	occurred at the treatment occurred at the tr	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as st	ated. the cause(s)
		To the within 2 To the complet	M	29b. Signature and title	e of certifier	heroe	mg		29c. Licen	o 60105	-	29d. Date si APRIL	gned (Month,	Day, Year)
		2		30. Name and address		p completed cause		3a) (Type.	Print) CUTTON	408mm	E BOLL	mwak	E WD	21229.
		Sta Regist		31. Date filed (Month,		1AY 0 4 20	gistrar's Signatur							

			T = For Stata Registrar	State of M	aryland		artment of H			_	•	2111	15	The state of the s	015
			Negistrar Decedent's Name (First, Middle, Last)			timouto or	Doda		2. Date of De				3. Time of	f Death
	Physici		Juliann Bake	r Bosn	ic					Month April	Day		өөг	1910) м
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location	of Death			County of			
			Shady Grove Hosp	ital			Rock	ville				Mont	gome	rv	
	Funeral		5. Social Security Number 6. Se	,	je (In yrs. la 58	ast birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da NOV • 20	th y, Year)	9	. Birthpla	ace (State o	
	Director		170-30-2500 Usual Residence of Decedent	J.W. 2 PAT. (00	Yrs.				Nov. 20	0, 19	936	Penr	ńsylva	nia
	land		10a. State 10b. County		10c. City,	, Town or Lo	cation						10	d. Inside C	ity Limits
	Mary fah	ţō	MD Montgo	mery	(German	town							1 XYes	2 🗆 No
	or 28a	Director	10e. Street and Number				10f. Zip Code	· · · · · · · · · · · · · · · · · · ·			10g. Citiz	zen of Wha	at Count	ry?	
	23a c	alD	18304 Metz Drive				20	0874			Uni	ited	Stat	es	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	•	3. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Or an, Mexica	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	. 1	14. Race - Black,	America White, e		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 □ If Yes, GiveX Year or Dates:	No		1□Yes 2√□No	Specify	:			Specify:	wh	ite	
윽	d within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-f ahow The M-circal Examiner must be notified at	edt	15. Decedent's Edu			16a, Dece	dent's Usual Occur	pation			16b. Kir	nd of Busin			
7		Completed	(Specify only highest grad	e completed) College (1-4or:	5+)	(Give	kind of work done DO NOT use retire	during mos	st of worki	ing				,	
212	al Hygiene. other than "	mo.	Liementary/Secondary (0-12)	2	34)		Homemake	er		_		home	e		
밀	be filed ital Hygie id other event, II	Be (17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle,	Maiden	Sumame)			
Maryland 21215-0036		2	Andrew Baker						Mario			Baker			
Mar	0 0 0	6 N	19a. Informant's Name/Relationship (T) Richard Bosnic		а		ng Address <i>(Street</i> 4 Metz Di					Town, Sta 208	_ :	Code)	
	1 and 2 Health tem 27 I		20a. Method of Disposition	, Habban			sition (Name of	1100		Date		cation - Cit		vn. State	
п	Pages nent of int: If it		1 ☐ Burial 2 【XCremation 3 ☐ F		CO	metery, crer	natory or other pla ke Cremat	.	5/3/	05			-		
Baltimore,	구두본글		21. Signature of Funeral Service Licent		One					and the second s		tsvi		MD	
ä	Department of the concession o		> Stysley John	ian .	M0038.		. Name and Addre Rapp Fune Avenue Si				n Se 209		es	933 G	ist
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused	d the death.									Approximat Interval Bet	te tween
	Pnysician	3 11	Immediate Cause (Final disease or condition	aspi	rati.	on	pneun	noni	a					Clay	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								- fo	
	LAUIIIIICI	-	Sequentially list conditions,	bb.	2 000000000	ence of									
	ted	nin	if any, leading to immediate cause. Enter Under, in Cause (Disease or injury	Due to (01 as	a consequ	erice cr).									
,	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):									
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical		d											
9	tificate ng phys as the	0 1											14.		
Вох	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth			Ectopic pregnanc	y			2	3d. Date o		,	Year
O.	at the dea by the at tached fo	Physician/M	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of dea	ath 5□	Other (specify)		-			WOITH	,	Jay	real
Ф	that the		Part II. Other significant conditions co	ntributing to death b	out not resul	lting in the u	nderlying cause giv	en in Part	l.	23e. Did to	obacco us	se contribu	ite to the	e cause of c	death?
Vital Records,	uires signe ld be	d by		•			, , , , , , , , , , , , , , , , , , , ,			1 🗆 Y	res 2	No 3[] Proba	ibly 4 □t	Unknown
Sor	w require been significant	ompieted								24a. Was	an	24b. Wer	e autop	sy findings	available
Re	0 - 0	dwo									rmed?	prio dea	r to com th?	pletion of c	ause of
tal		e C	25. Was case referred to medical					26. Place	e of Death	1 Yes	ne)		Yes 2	2110	
	dir	To B	examiner?	lospital:	ent 2 🗆 E	R/Outpatien	t 3 DOA Ott	ner: 4□Ni	ursing Hor	ne 5 Resid	dence 6	Other (Specify)	1	
n of			27. Manner of Death	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Injui Woo	ry at rk?	2	28d. Describe h	now injury	occurred			
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2	-						
Division	in Dir	Certification:	4 Homicide determined	28e. Place of Inj building, et	c. (Specify)	ne, farm, str	eet, factory, office			28f. Location (S City or Tow			or Hurai	Houte Num	iber,
_	e Hospital or 24 hours afte e Funaral Dir letely filled in		29a. Certifier Certifying Phy	sician: To the best	of my know	vledge, death	occurred at the ti	me. date ar	nd place, a	and due to the	cause(s)	and manne	er as sta	ted.	
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis o and manner st	f examination	on and/or in	estigation, in my o	pinion, dea	ath occurre	ed at the time,	date and	place, and	due to 1	the cause(s	s)
	within 2 To the	Ž	29b. Signature and title of certifier	41 7	7- /	7	29c. Licens					signed (A		-	•
•	N		> Pflicia J.	Misery	me	MI	D 50	7738	5		Ma	4, 1.	, 20	205	
,	10		30. Name and address of person who ca	empleted cause of c	leath (Item	23a) (Type, Mecl	Print) i Call Co.	nter	Dr	rive a	Pock	oller	NID	20	850
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	ure	Cools	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

and Items State of Maryland 7 Department of Health and Mental Hygiene () () 5
23a, Ptii, 25, 27, 28a, fireper, MF, 6843, 05/03/05dhb

			1 - State Registrar		7,28 certificate of Geath, 05/	Reg. N	lo.
	Physici	an	1. Decedent's Name (First, Middle, Last)	100 11			ay Year 3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give st	treet and number)	4b. City, Town, or Location of Death	Danvey 4	Ic. County of Death
	Examin	ei	Union Memor	ial	Baltimore		NIA
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Yea	9. Birthelace (State or Foreign Country)
	Director		Usual Residence of Decedent		110.	10-26-	10 411
	aryland show	_	10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits 1 ☐ Yes 2 TVNo
	tha Mi	ecto	10e. Street and Number	re	101, Zip Code	100.0	Citizen of What Country?
	3a or	DIE	9241 Eduni (Pirale.	2183		USA
	r deat	Funeral Director		Was Decedent Ever in U.S Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Guban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	iges 1 and 2 should be filad within 72 hours after death with tha Maryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or itams 23s or 28s-f show or other traumatic avent, the Medical Examinat must be radified at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: RIAK
2-0	72 hou	eted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occupation (Give kind of work done during most of wor	rking 16b.	Kind of Business/Industry
21215-0036	within 72 ene. than "na'	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		(mstriction)
	oe filad al Hygid d othar avant,	a)	17 Father's Name (First, Middle, Last)	7.3		me (First, Middle, Maide	en Sumame)
Maryland	should be nd Mental markad c	ToB	Kobert E Carter,	JR	Linda	C. Tay	IOR
Mar	d 2 sho th and t7 is m traum	1	19a. Informant's Name/Relationship (Typ	Father	19b. Mailing Address (Street and Number or Ru	ir I Route Number, Cify	v or Town, State, Zip Code)
re,	es 1 and 2 of Health f Itam 27 r othar tr		20a. Method of Disposition	- ce	ace of Disposition (Name of metery, crematory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	Pa ant ury		1	emoval from State Du	laney Valley 1-1	5-05-11	monune MD
Balt	parmit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	of	21 Name and Idress of Facility V	d Dondell	Story WU 3/133
			23a. Part1. Enter the disease, or complice	cations that caused the death.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pnysician	V 5	Immediate Cause (Final disease or condition	Aspiration			Onset and Death
	/Medical		resulting in death)				
	Examiner		1 document of the control of the con	Due to (or as a conseque	ence of):		
	Examiner	Jer			\sim	An annual of the same of the s	R
1	Examiner	caminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseque	\sim	ED BY MEDICAL EXAMINE	R
.60,	Examiner	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		\sim	ED BY MEDICAL EXAMINE	R
68760,	tificate be executed graphysician and as the burial-transit	ledical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	ED BY MEDICAL EXAMINE	R
	tificate be executed graphysician and as the burial-transit	ledical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequence of the consequence of	ence of): CERTIFICATION APPROVI	ED BY MEDICAL EXAMINE	23d. Date of delivery Month Day Year
. Box	tificate be executed graphysician and as the burial-transit	ledical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of pregnance)	ence of): CERTIFICATION APPROVI	ED BY MEDICAL EXAMINE	23d. Date of delivery
P.O. Box	tificate be executed graphysician and as the burial-transit	y Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions	Due to (or as a consequence) Due to (or as a consequence) Bc. If yes, outcome of pregnant 1	ence of): CERTIFICATION APPROVI	23e. Did tobacco	23d. Date of delivery Month Day Year o use contribute to the cause of death?
P.O. Box	tificate be executed graphysician and as the burial-transit	ed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions mellitus, Females.	Due to (or as a consequence) Due to (or as a consequence) Bc. If yes, outcome of pregnant 1	ence of): CERTIFICATION APPROVI	23e. Did tobacco 1 ☐ Yes	23d. Date of delivery Month Day Year o use contribute to the cause of death?
P.O. Box	aw requires that the death certificate be executed to be executed to be signed by the attending physician and to should be detached for use as the burial-transit to be as the burial-transit to be as the burial-transit.	ed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions	Due to (or as a consequence) Due to (or as a consequence) Bc. If yes, outcome of pregnant 1	ence of): CERTIFICATION APPROVI	23e. Did tobacco	23d. Date of delivery Month Day Year b use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Ponknown} \) 24b. Were autopsy findings available prior to completion of cause of
Records, P.O. Box	The law requires that the death certificate be executed to the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	e Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions mellitus, Females.	Due to (or as a consequence) Due to (or as a consequence) Bc. If yes, outcome of pregnant 1	ence of): CERTIFICATION APPROVI	23e. Did tobacco	23d. Date of delivery Month Day Year Duse contribute to the cause of death? 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?
Vital Records, P.O. Box	The law requires that the death certificate be executed to the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions mellitus, Femur 25. Was case referred to medical exampler? 1 Yes 2 No He	Due to (or as a consequence of pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of decent of the stage renains and stage renains of the stage renains of	ence of): ence of): CERTIFICATION APPROVIDED TO SERVICE TO SERVI	23e. Did tobacco	23d. Date of delivery Month Day Year b use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Ponknown} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) 6 \(\text{Other} \) (Specify)
of Vital Records, P.O. Box	ing Physician: The law requires that the death certificate ba executed by the physician and After this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions mellitus, Femur 25. Was case referred to medical exampler? 1 Yes 2 No	Due to (or as a consequence of pregnant at time of design Unknown tributing to death but not resulted and extra pregnant at time of design Unknown tributing to death but not resulted and extra pregnant at time of design Unknown tributing to death but not resulted and extra pregnant at time of design Unknown tributing to death but not resulted and extra pregnant at time of design Unknown tributing to death but not resulted and extra pregnant at time of design Unknown 2	ence of): CERTIFICATION APPROVIDED TO SERVOUT A STATE OF THE CONTROL OF THE CONT	23e. Did tobacco	23d. Date of delivery Month Day Year b use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Ponknown} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) 6 \(\text{Other} \) (Specify) jury occurred
of Vital Records, P.O. Box	Attending Physician: The law requires that the death certificate be executed to death. Actor: After this certificate has been signed by the attending physician and property the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contiliable tes mellitus, Femur 25. Was case referred to medical exampler? 1 Yes 2 No	Due to (or as a consequence of the consequence of t	ence of): CERTIFICATION APPROVIDED TO SET OF THE PROPERTY OF	23e. Did tobacco 1 Yes 24a. Was an autopsy performed? 1 Yes 2 Nath (Check only one) lome 5 Residence 28d. Describe how in Fell in ba	23d. Date of delivery Month Day Year Do use contribute to the cause of death? 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) jury occurred 2 throom
Vital Records, P.O. Box	Attending Physician: The law requires that the death certificate be executed to death. Actor: After this certificate has been signed by the attending physician and property the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions continued in the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examper? 1 Yes 2 No House Hou	Due to (or as a consequence of the consequence of t	ence of): ence of): certification APPROVI death 3 Dectopic pregnancy ath 5 Other (specify) Iting in the underlying cause given in Part I. It disease, Fractured 26. Place of Death D	23e. Did tobacco 1 Yes 24a. Was an autopsy performed? 1 Yes 2 N ath (Check only one) lome 5 Residence 28d. Describe how inj Fell in baccity or Town, Sta Future Car	23d. Date of delivery Month Day Year Do use contribute to the cause of death? 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) jury occurred athroom and Number or Rural Route Number, tel Ce Hon wood 2700 N.
of Vital Records, P.O. Box	pital or Attending Physician: The law requires that the death certificate be executed to a siler death. aral Director: After this certificate has been signed by the attending physician and manal Director. After this certificate be been signed by the attending physician and milled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnant at time of desemble of the stage of the sta	ence of): ence of): certification APPROVI death 3 Ectopic pregnancy lath 5 Other (specify) Iting in the underlying cause given in Part I. Il disease, Fractured 26. Place of Dea ER/Outpatient 3 DOA Other: 4 Nursing H 28b. Time of Injury a M 1 Yes 2 Xes The province of the cattery of the catter	23e. Did tobacco 1 Yes 24a. Was an autopsy performed? 1 Yes 2 Nath (Check only one) lome 5 Residence 28d. Describe how in Fell in baccing of the City or Town, Staffuture Car	23d. Date of delivery Month Day Year Duse contribute to the cause of death? 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) jury occurred Athrom and Number or Rural Route Number, (16) The Holl Wood 2700 No. (5) an manner as staled.
of Vital Records, P.O. Box	pital or Attending Physician: The law requires that the death certificate be executed to a siler death. aral Director: After this certificate has been signed by the attending physician and manal Director. After this certificate be been signed by the attending physician and milled in by the funeral director, page 2 should be detached for use as the burial-transit	ertification; To Be Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions continuates and part of the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical exampler? 1 Yes 2 No House	Due to (or as a consequence of pregnant at time of deign of the stage of liner of	ence of): CERTIFICATION APPROVIDED TO SERVOUT A STATE OF THE CONTROL OF THE CONT	23e. Did tobacco	23d. Date of delivery Month Day Year Duse contribute to the cause of death? 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Pes 2 No 6 Other (Specify) iuny occurred athrom and Number or Rural Route Number, itel The Hone wood 2700 No. (s) an manner as staled. Indicate signed (Month, Day, Year)
of Vital Records, P.O. Box	Hospital or Attending Physician: The law requires that the death certificate ba executed to the theore after death. Funaral Director: After this certificate has been signed by the attending physician and present of the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	edical Certification; To Be Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnant at time of decent of the stage	ence of): CERTIFICATION APPROVIDED TO SERVOUT A STATE OF THE CONTROL OF THE CONT	23e. Did tobacco	23d. Date of delivery Month Day Year Duse contribute to the cause of death? 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Pes 2 No 6 Other (Specify) iuny occurred athrom and Number or Rural Route Number, itel The Hone wood 2700 No. (s) an manner as staled. Indicate signed (Month, Day, Year)
of Vital Records, P.O. Box	pital or Attending Physician: The law requires that the death certificate be executed to a siler death. aral Director: After this certificate has been signed by the attending physician and manal Director. After this certificate be been signed by the attending physician and milled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnant at time of design of the stage	ence of): CERTIFICATION APPROVIDED TO SERVOUT A STATE OF THE CONTROL OF THE CONT	23e. Did tobacco	23d. Date of delivery Month Day Year Duse contribute to the cause of death? 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 2 No 6 Other (Specify) iury occurred Athroom and Number or Rural Route Number, itely The Hon wood 2700 No. s) an manner as stated. Indicate the property of the property

DOLOLES MALSH CHAPMAN

			Please I	ype or Print in Black I		•	•
			For	State of Maryland / Dep	partment of Health	and Mental Hygie	ne
			1- State Registrar amend item	#20b&c per fh g843	ergiio6ti05f Death	Reg.	N2 005 15017
	Physici /Medic		Decedent's Name (First, Middle, Last)	Chapma	N		Day Year 08:13 P M
)	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location BALTIMOL	of Death	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex				9. Birth place (State or Foreign)
	pu ,		Usual Residence of Decedent 10a, State 10b, County	100 000 Town			1 401 10000
	72 hours after death with the Maryland natural', or ttems 23a or 28a-f ahow Iteal Exafra wer nati be rodified at	ctor	10a. State 10b. County	10c. City, Town or	in One		10d Inside City Limits 1
	th with th	Funeral Director	10e. Street and Number 56.444 Pipon	oor Drive	10f. Zip Code	10g.	Citizen of What Country?
	Items ?	uner	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	רל hours after death w "natural", or Items 23a מלוכנון בתנוני מצור		3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify		Specify: Black
21	within 72 ene. than "nat	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) (Gi	edent's Usual Occupation re kind of work done during mos . DO NOT use retired)	at of working	D. C. al. C.
121	filed with Hygiene Athar thai		17. Father's Name (First, Middle, Last)	LYEARSDIS	TIBUTION AA	10/45/5	5648
anc	ould be fi Mental I- arkad ot atic evar	To Be	Cha de Santo	1000	D. Moth	CO HO	den Sumame)
Maryland	should and Men ia marka aumatic	F	19a. Informant's Name/Relationship (Ty	pe, Frint) 1 h G. w 119b. Ma	iling Address (Street and Numb	er or Rural Route Number. Ci	ity or Town, State, Zip Code)
	1 and 2 s Health ar tam 27 ia		Paul Char	May 56	44 Pione	er DR. Bo	216-MD21214
Baltimore,	Se to E		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	SON FOREST CEM	n 5/405	Location - City or Town, State WINGSMILLS, MD, 21117
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	Suit	27 Name and Address of Facility	dere truse	sal Services
i.			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not e	nter the mode of dying, such as	cardiac or respiratory arrest,	Approximate Interval Between
	Prysician		Immediate Cause (Final disease or condition	CARDIOPUL	MONAKY .	PAILURE	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	Viente Common de la common de l		
		10	Sequentially list conditions if any, leading to immediate	Due to (or as a consequence of):	1 EMBOLI	SM	
	nsit	nine	cause. Enter Underlying Cause (Disease or injury	bus to (or us a consequence or).			
,	te be executed ysician and ie burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			
760,	te be ysicia ne bur	cal		J			
68	leath certificate k attending physic	Medi	IF FEMALE:		-		
Вох	ath ce ttendii	an/h	23b. Was decedent pregnant in the past 12 poinths?		☐Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	0 0 0	by Physician/Medi	1 Yes 2 No 9 Unknown	4☐Pregnant at time of death 5 9☐ Unknown	Other (specify)		Worth Day real
Is, P	w requires that the been signed by the should be detache	by Pi	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part	. 23a. Did tobaci	co use contribute to the cause of death?
Ö	- 0 0	etec		11(20)		24a. Was an	
of Vital Records,	e la has je 2	Completed	HYPEKTE DIANETE			autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ital	ician: Th certificate rector, pag	0	25. Was case referred to medical	5	26. Place	1 ☐ Yes 2 ☑ a of Death (Check only one)	No 1 Yes 2 No
/	Phyaician: r this certific ral director,	To B	examiner?	lospital: Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 N	ursing Home 5 Residence	6 ☐ Other (Specify)
	fte In		27. M. m. r of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	njury occurred
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, S.	t and Number or Rural Route Number, tate)
_	spital naral / filled		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, de	ath occurred at the time, date ar	nd place, and due to the cause	e(s) and manner as stated.
)	ha Ho in 24 I ha Fu pletely	Medical	(Check only 2 Medical Examile one)	ner: On the basis of examination and/or and manner stated.	investigation, in my opinion, dea	ith occurred at the time, date	and place, and due to the cause(s)
	To t Comp	Σ	29b. Signature and title of certifier	1. 100	29c. License number	8	Date signed (Month, Day, Year)
	4		> Waller Ball	11/9	Keg 000	/	7:101 2005
4	8		30. Name and address of person who co		e, Print)	5601 LOCH 1	AVEN POULEVALD
	- Sta	te	31. Date filed (Month, Day, Year)			BULLIMONE - 1	VID - LI L5 %
Ç	Registr		MAY 0	4 2005	STORE OF THE PROPERTY OF THE P		

			State of Maryland / Department of Health and N Certificate of Death		ene g. No A A	g con	F* 0 1 0
	Dhysisi	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death	200	Year 3	. Time of Death
	Physici /Medi	cal	4a. Facility Name (If not institution, give street end number) 4b. City, Town, or L.	5-2	- 05 4c. County o		1.30AM
~	Examir	ier	2	nore	4c. County o	Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth	Year)	9. Birthplace Country)	(Stete or Foreign
	Director	0	27-093430 XM 2 F 87 Yrs. Months 283 No. 1	5/6/	17 N	orth(gro/ina
	ryland how		10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Limits
	he Ma 28e-f s	ecto	10e. Street and Number	146	g. Citizen of Wh	at Country	1 XYes 2 □ No
	3a or	i	5813 Hali 2011 2 Aliana Aliana 2012 2012 2012		(1.54	L	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other traumatic avant, he Medical Examinar must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American White, etc.	ndian,
20	rs afte , or It	by Ft	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No IV es, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:		Specify!	Bla	ck
21215-0020	2 hour	ted t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	ring 1	6b. Kind of Bus	iness/Indust	ry
121	ithin 7 ne. nan "n	Completed	Elementary Secondary (0-12) College (1-4or 5+)	0	Radkla	1 -	Shol
d 2	filed w Hygiei ther tl		17. Father's Name (First, Middle, Lest) 18. Mother's Name	e (First, Middle, M	laiden Surname,	nam	Siece
/lan	uld be Aental rked o	To Be	Jim Clark Nava	sie C	sope,	e_	
Maryland	2 should n and Men is marke raumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	ral Route Number,	City of Town, S		
	1 and Health em 27		Affice Blackwall Daughter 5813 Howyn 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date 2	10c. Location - C		1212 State
Baltimore,	Pages ent of nt: If its ry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	5/1/05	Batto	. 11	
alti	pemit. F Departm Importar any injui		21. Signature of Funeral Service Licensee	10.77	real.	Seve	rices)
•	8 9 E 8 9		hun M. Sur Hans Work	Id Ba	1to.11	$D \cdot 2$	142
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	št,	Ap Int Or	proximate erval Between iset and Death
	Physician /Medical		Immediate Cause (Final disease or condition a. SEPTICEMIA - cluse 1	To		,	
	Examiner	ايا	Due to (or as a consequence of):	1	general control of the control of th		occie;
	nted I Insit	Examiner	. Occlusive Disease of The	tile	ries		
oʻ	an and	Еха	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			1	
68760,	eath certificate be executed attending physician and for use as the burial-transit	edlcal	Cause (Disease or injury that initiated events that initiated events to compact the country of t				
	certific ding p		d				
Ä.	death le atter	sicla	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tol	pacco use cont	ribute to the	e cause of death?
P.0	aw requires that the death cer as been signed by the attendir 2 should be detached for use	Completed by Physiclan/N	Hypertensin - Carinsma Oli	1 □ Ye	e 2□No 3	B ☐ Probab	y 4 Unknown
ds,	uires the signer of the control of t	d by	Carcinema of prestate	24a. Was ar		24b. Were	autopsy findings
Ö	w requ	plete	Carcinoma of prestate	perform	ed?	compl of dea	ole prior to etion of cause th?
Ä	The law ate has page 2	E O		1□ Ye	s 2 000	1 □ Y	es 2□ No
Vita	Iclen: Sertific Pector,	Be	examiner?	th (Check only one			
Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death cerr death. r death. sctor: Atter this certificate has been signed by the attendinby the funeral director, page 2 should be detached for use	ت. ح	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Resider 28d. Describe ho			
ion	anding sath. or: Afte he fun	ation	2 Accident investigation M 1 Yes 2 No				
j Ņ	or Atter of the de Director in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town,	eet and Number State)	or Rurel Ro	oute Number,
	To the Hospital or Attending Physicien: The kaithin 24 hours after death. To the Funaral Diractor: After this certificate hat completely filled in by the funeral director, page	a Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the ca	use(s) and man	ner as state	d.
	the Ho nin 24 I the Fu	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.				
	With Tool	Σ	29b. Signature and title effectifier 29c. License number		d. Date signed		
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/			
	V		AH.GARADIMO 7660 OSLER DV.	Tense.	1 116	0 2	1264
S.	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year :15am 05 02 05 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NUISINGHOME 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Inside City Limits 1 1 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status I □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Q 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, Date 20c. Location Met lod of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee lun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ndometya Due to (or as a consequence of): डेक्टाइ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (a as a consequence of). Examiner SCVI Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Winknown 1 Tyes 2 No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 20 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes Certification; To 4 Sing Home 5 Residence 6 Other (Specify) 2□M0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 T Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Funeral Director

28e-f show

Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural," or items 23e or 28e-f shot eny injury or other treumatic event, the Movical Examinat must be notified at once.

Physician

Examiner

use as the burial-transit

attending physician and for use as the burial-trar

sate has been signed by the a page 2 should be detached to

certificate has

/Medical

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23

Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director,

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

Baltimore, Maryland 21215-0020

Box 68760.

1. Decedent's Name (First, Middle, Last)

Physician HAZEL CARTER 29 2005 April 5:30am /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore Future Care Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 20 F 96 Yrs. Director 251-24-2055 SC 03 Usuel Residence of Decedent 2 should be filed within 72 hours efter deeth with the Marylend end Mentel Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYes 2□ No Director Baltimore NA MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21244 U.S.A. 3507 Rockdale Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th grade na House <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tina Acie Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 end 2 ment of Health e. nt: if Item 27 Is. 21244 3507 Rockdale Ct., Baltimore, Md James Carter-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ▼□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Depentment of Important: If eny injury or 5/5/05 Pikesville, Md Druid Ridge 21. Fign ture of Funeral Service License 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 八 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical e. CEREBRO VASCULAR Unknown Examiner Due to (or es a consequence of): Physician/Medical Examiner HYPEIZTENSION Unles Attending Physician: The lew requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or as e consequence of). 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ADVANCED DEMENTIA ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? VASLULAR DISEASE. PERIPHERAL 1 Yes 2 No 1 ☐ Yes 2 ☐ No Colon LANCER 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Neturel 2 Accident efter death. Director: Aft 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29/05 ()0059056 D SALUJA MD 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year)
WAY 0 4 2005 Royal Ave Balt

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

DHMH 16 Rev 6/95

Registrar

			1 - State State Registrar	of Maryland / Depa	delible Ink. Ensure A artment of Health and rtificate of Death	Mental Hygie	_	15021
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	ute R		2. Date of Death Month	Day Yeer 5 ZOOS	3. Time of Death 11:40 ам
	Examin		4a. Facility Name (If not institution, give street and n Riverview Nursing Ho		4b. City, Town, or Location of Deat	h	4c. County of Death	
_	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Essex If Under 1 Year If Under 24 Hrs		Baltimore 9. Birthpla	ice (State or Foreign
L	Director		018-09-4480 1X M 2□F	84 Yrs.	Months Days Hours Min.	Dec. 23,	Mass.	
	ryland ihow		10a. State 10b. County Md. Baltimore	10c. City, Town or Lo			100	d. Inside City Limits
	he Ma 28a-fa	Director		Dunda		10-	Ciair a statut a Company	1 ☐ Yes 2Ã No
	h with t	ai Dir	10e. Street and Number 3406 Yorkway		10f. Zip Code 21222	Tog	. Citizen of What Countr USA	y:
920	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or itams 23a or 28a-f ahow event, the Medical Event front most be indiffied at	by Funeral	Armed F	2 🔼 No Sive	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Black, White, et Specify: Whit	ic.
215-0036	72 hou natura	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occupation kind of work done during most of wo	rking 16	b. Kind of Business/Indu	istry
7	within ene. than	mpi		(1-4or 5+) life.	DO NOT use retired) eral Accounting		Federal Go	ov't
ם פ		Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Na	ne (First, Middle, Ma	iden Sumame)	
yland	2 should be and Mental is marked o	To B	Edward E. Carpenter		Lillia		.xon	
- T	de la		19a. Informant's Name/Relationship (Type, Print) James Carpenter brot		ng Address <i>(Str</i> eet and Number or Ri 5 Yorkway Dundal	ural Route Number, C k Md. 2122	•	Code)
e,	item 2		20a. Method of Disposition	20b. Place of Dispo	-	Date 20	c. Location - City or Tow	n, State
galtimor	Page ment c ant: If		1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Cedar Hi	11 Cem. 20	05	len Burie	
gal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra once.		21. Signature of Funeral Service Licensee	alles 5	2. Name and Address of Facility Connelly Funeral 1 7110 Sollers Point	long Of Du	ndalk	
	2 10		23a. Part1. Enter the disease or complications that shock, or heart failure list only one cause on					Approximate nterval Between
	Physician		Immediate Cause (Final	The Renal			(Onset and Death
	/Medical Examiner		resulting in death)	o (or as a consequence of):				me y e gut
		iner	cause. Enter Underlying	C (or as a consequence of j.				· · · · · · · · · · · · · · · · · · ·
,00/	e be executed rsician and e burial-transit	cal Examine	Cause (Disease or injury that initiated events resulting in death) Last	o (or as a consequence of):				
BOX PR	law requires that the death certificate is been signed by the attending physic should be detached for use as the it.	Physician/Medic	23b. was decedent pregnant	utcome of pregnancy	□Ectopic pregnancy		23d. Date of delivery	
	t the deat by the att ached for	hysicia		gnant at time of death 5 [Other (specify)		Month D	ay Year
cords, r	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to Clut onic Preserva	death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the	
ဝင္ပ	e law re has bee ge 2 sho	Completed	Hypertension with	Curonay Art	ery Diane	24a. Was an autopsy	prior to comp	sy findings available pletion of cause of
Ĭ	Th ate pag			soo i suc som a	caident	performe 1 ☐ Yes 2 ☐	d? death?	
VITA	ysician: The is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatier		ath (Check only one)	ce 6 □Other (Specify)	
on or	Ph er th eral	-	27. Manner of Death 28a. Date	e of Injury onth, Day Year) 28b. Time o Injury		28d. Describe how		
DIVISION	To the Hospital or Attending within 24 hours after death. To tha Funeral Director: Afte completely filled in by the fund	Certification:	3 Suicide 6 Could not be	ce of Injury - At home, farm, sti ding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural F State)	Route Number,
	e Hospite 24 hours a Funera letely fille	Medical C	(Check only 2 Medical Examiner: On the	he best of my knowledge, deat basis of examination and/or in inner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	a, and due to the causured at the time, date	se(s) and manner as state and place, and due to the	ted. he cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License number		. Date signed (Month, Da	
	/		Milure (leeder	4Đ	D19667	0	5.03 200	5
{ /	6		30. Name and address of person who completed cal		AND THE RESERVE OF THE PARTY OF			
	Sta	ate	MICHAEL H. SCHWARTZ 31. Date filed (Month, Day, Year); 32.	Registrar's Signature	LITIMORE, MD 21225			
	Registi	rar	MAY 0 4 2005	Registrar's Signature				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				per FH, 6848,1	0/26/05 Certi	dhb ificate of	Death	icinai i iy	Reg. No.	05	15022
	Physic	ian	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ath Day	Year_	3. Time of Death
	/Medi		Emerson Carter					APRIL	26	ws	1450
)	Exami	ner	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or Lo		4c. County	of Death	
Н			Anatomy Board 5. Social Security Number 6. Se	7. Age (In yrs.	last histhday)	If Under 1 Year	Baltimon If Under 24 Hrs.		<u> </u>	0.510	(2)
	Funeral Director		212-60-3227 Usual Residence of Decedent	7. Age (,,, y, s.		Months Days		8. Date of Birt (Month, Day 08/18/	1953	9. Birthp Coun MD	lace (State or Foreign try)
	yland now		10a. State 10b. County	10c. Cit	ty, Town or Loca	ition			10d. Inside City Limi		
	a-fsh	ģ	MD	Bal	timore						1 X Yes 2 □ No
	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	238	a I	515 Fulton Ave.			21223		τ	JSA		
21215-0020	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "netural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evarcinal towards to the filed at 88.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates:		as Decedent of I es, specify Cub	dispanic Origin? (Spian, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White, c Bla	etc.
15-0	n 72 ho "netur	Completed by	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deceder (Give kir.	nt's Usual Occup nd of work done	Dation during most of works d)	ing	16b. Kind of Bu	usiness/Inc	lustry
212	withi iene. than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	Labor		u)		Fast Fo	Бос	
b	Hyg Hyg other	BeC	17. Father's Name (First, Middle, Last)		Labor	<u> </u>	18. Mother's Name				
Maryland	uld be Jenta rked tic av	To B	Cornelius Carte	r			Mamie Ev	ans			
lan)	2 sho and N		19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailing	Address (Street	and Number or Rura	al Route Numbe	r, City or Town,	State, Zip	Code)
	and 2 ealth n 27 I		Rosalie Carter				St. Balt	o. MD.	2121	7	
Baltimore,	permit. Pages 1 a Department of Her mportant: If item any Injury or othe ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. P Removal from State	Place of Dispositi emetery, cremat	ion (Name of tory or other pla	ce)	Date	20c. Location -	City or To	wn, State
Ħ	: Pag tmeni tant:	١.	4 ☐ Donation 5 ☐ Other (Specify)	1 Mt	. Carm		5-	-3-05 I	Balto.	MD	
Bal	permit. F Departme importan any Injur		21. Signature of Funeral Service Licens	ee /	Wes	lame and Addre	ss of Facility avis Jr.	Funer	al Hor	ne	
	20200		Melslay (4)	will	200	7	orn Arro	D-1+	MD '		1
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death ne cause on each line.	h. Do not enter t	the mode of dyir	ng, such as cardiac c	r respiratory arr	est,		Approximate Interval Between
)	Physician /Medical		Immediate Cause (Final	A							Onset and Death
	Examiner		disease or condition resulting in death)	ATHEROSCLE			DIOVASCU	CASC &	112017	E	NOWTHS
		ē		Due to (o	r as a conseque	nce of):				i	
, (requires thet the death certificate be executed neen signed by the attending physician and hould be deteched for use as the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequer	nce of):				-	
68760,	te be ysicia	cai	I triat initiated events	Due to for	as a consecue	courft.					
89	rtifica ng ph as th	Medicai	resulting in death) Last		30 0 000000	no uy.					
Box	th cer tendir or use			i				-			
	e dea the at ned fo	Physician/	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the unde	orlying cause giv	en in Part I.	23b. Did to	bacco use con	tribute to	the cause of death?
P.0	that the de ned by the a deteched f		OSTEVARHRITI	5				1 □ Y	es 2 🗆 No	3 🗆 Probe	ably & Unknown
ds,	ires ti signe d be d	d by	Os som the							0.41- 14/	
of Vital Records,	aw 1st 2s	Completed	- 4					24a. Was a perforr		avai	re autopsy findings lable prior to ipletion of cause eath?
<u> </u>								1 □ Ye	s a□No	1 🗆	Yes 2□No
Z.	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:		Oth	26. Place of Death	•	•		
o	this aldi	5	1 ☐ Yes 2 ☐ No Control Contro	1 □ Inpatient 2 □ E		3□ DOA Oth	Nursing Hon				
o	ding h. After funer	를	VINatural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	28c. Injun Work	yat k? Yes 2 □ No	8d. Describe ho	w injury occurre	a	
	or Attending ster death. Director: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, street,			8f. Location (Sta City or Town		r or Rural	Route Number,
_	To the Hospital or Attending I within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	edicai Co	29a. Certifier (Check only one) 2□ Medical Examir	sician: To the best of my knowner: On the basis of examinatiand manner stated.	vledge, death oc ion and/or invest	curred at the timitigation, in my op	ne, date and place, a pinion, death occurre	nd due to the ca d at the time, da	use(s) and man	ner as sta nd due to t	ted. he cause(s)
	To the Ho within 24 I To the Fu completel	Me	29b. Signature and title of certifier	~		29c. License	e number	29	d. Date signed	(Month, D	ay, Year)
			· Wellow 2	$M \cdot 1$.		000	CRUE =	$A \mid A$	PRIL	29	2005
	1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Prin	nt)	, ,		1 1 1		
			NAME OF OR (CE	ASAR 821	NORT	TH EL	ITAW S	TREE	=7	51.	201
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 20	32. egistrar's Signat	y Age						

EMERSON

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #5 PER FH G843 5/23/195cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Beryl D. Corbin 1015 AM Mar 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Healthcare N/A Agnes Baltmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Fe. 12, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 1 F 82 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Exaction or must be rediffed at Director MD X□ Yes 2□ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3909 Wilkens Avenue 21229 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercited-1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeping A & P Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Peschua Beryl Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westley Corbin Husband 3909 Wilkens Ave., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State complety, cromatory or other place)
Meadowridge
Memorial Park 1 Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify) 15-6-2005 Elkridge, MD Signature of Funeral Service Licensee 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician disease or condition resulting in death) じろてろのほう /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit List and Physician/Medical 10(2) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 11950 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပို 1 ☐ Yes 2 ☑ No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 5/3/05 D31322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADEN CHOICE IN, CATORSVILLE ADZIZZE GARG 716 KID 32. Registres Signature State Registrar 2005

			For State Registrar	State of Marylar	•	artment of <i>rtificate o</i> a			giene Reg. No 3	~ ~~	11.00
	Physici /Medic		Decedent's Name (First, Middle, Last)	Yu Chen Ch	nan			2. Date of De. Month May 1	Day	Year	3. Time of Death 4:49 A M
	Examin		4a. Facility Name (If not institution, give single 7005 Natelli Woods			-	or Location of D		4c. Count	ty of Death	rv
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs M 2⊠F 87	. last birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24	Hrs. 8. Date of Birt (Month, Da Nov. 2,	th y, Year)	9. Birthp	place (State or Foreign htry)
	yland low		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	e Mar	ctor	Maryland Montgome	ry	Ве	thesda					1 ☐ Yes 2 ☑ No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		•
9	ges 1 and 2 should be filed within 72 hours efter deeth with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itema 23a or 28a-f show or other treumatic event, Ite Madical Examilitational by nutilitied at	by Funeral	7005 Natelli Woods 11. Marital Status 1	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 XNo If Yes, Give		Was Decedent of f Yes, specify Cu		n? (Specify Yes or No Puerto Rican, etc.)		ice - Americ ack, White,	can Indian,
Maryland 21215-0036	n 72 hours "natural", edical Exa	Completed by	3 ⊠Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade	Year or Dates:	16a. Deced	dent's Usual Occ kind of work don DO NOT use retii	upation	f working	Speci 16b. Kind of B	Asi	
212	jene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 2		maker	60)		Own	Home	!
land	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Lian Gen Chan					Name (First, Middle, L Dzi	Maiden Suma	me)	
lary	2 should and Missing is mail		19a. Informant's Name/Relationship (Typ	e, Print)				or Rural Route Numbe	-		
	1 and Health em 27 ther tr		Jane Moh/Daughter 20a. Method of Disposition	20b.	-	Natelli sition (Name of	Woods L	ane, Bethe	sda, Ma 20c. Location	-	
mor	Pages nent of H snt: If Ite ury or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State Mo	cemetery, cren ntgomer	natory or other pi	20	ay 4,			aryland
Baltimore,	permit. Pages 1 and 2 Department of Health 8 Importent: If Item 27 i any injury or other tre	j	21. Signature of Funeral Service Acense		RO RO	um, Inc. Name and Add bert A.	ress of Facility Pumphre	ey Funeral	Home/B	Chas	da-Chevy
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	1,55					014-3	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition resulting in death)	Acute Renal	l Failu	re					Onset and Death
	/Medical Examiner		resulting in death)	End Stage I		isease					
	MARKE	Jer	Sequentially fist conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury	Due to (or as a conse		10000				-	
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Respirator		ire					
68760,	ificate be executed g physician and as the burial-transit	edical E	d.	Consestive	,	Failure			_		
P.O. Box 6	ath cert	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnan Other (specify)	су			ate of delive onth	ery Day Year
ds, P.	uires that the de signed by the a ld be detached f	þ	Part II. Other significant conditions cont Pulmonary Edema	ributing to death but not re	sulting in the ur	nderlying cause g	iven in Part I.				ne cause of death?
Vital Records,	The law requisate has been page 2 should	Completed							rmed?	Were auto prior to cor death?	psy findings available mpletion of cause of
<u>E</u>		BeC	25. Was case referred to medical examiner?				26. Place of	1 ☐ Yes Death (Check only o		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
<u>o</u>	hys this al dii	2	1 ☐ Yes 2 ☑ No Ho	ospital: 1 Inpatient 2		1 3LI DUA		ng Home 5 🖾 Resid			y)
O	ding After fune	tlon	1 X Natural 5 Pending 2 ☐ Accident investigation	28a. Oate of Injury (Month, Day Year)	28b. Time of Injury	W	ury at ork?] Yes 2 [] No	28d. Describe h	iow injury occu	rred	
Division of	el or Attanding s after death. i Director: After id in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory, office)	28f. Location (5 City or Tox		ber or Rura	l Route Number,
	To the Hospitel of within 24 hours aft To the Funerel Discompletely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Exemination)	cien: To the best of my kn er: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the vestigation, in my	time, date and p opinion, death (place, and due to the operations of the time, of	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	withi To the	Σ	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signe	ed (Month,	Day, Year)
1	01/		// tuwz	mo		MI	31162	2	May 2,	2005	
1	V		30. Name and address of person who con Theresa A. Stone, I	4 D 730 24	th Stre	et N W	Washir	ngton, D.C	. 2003	7	
	Sta Registr		31. Date filed (Month, Day, Year) 0 4	2005 Registr's Sign	ature 2.	Grande					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:00 PM **Physician** 30 2005 /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Deeth Examiner TOWSON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Yrs. Funeral 9. Birthplace (State or Foreign Director Usual Residence of Decedent 10a State 10h Counts d 2 should be filed within 72 hours after death with the Marylan and Mantle Hyglene.
77 Is marked other than "natural", or ffems 23a or 28a-f show traumstic evant, the Madical Examinational Legicolified. 10c. City, Town or Location 10d. Inside City Limits MD Completed by Funeral Director 1 ☐ Yes 2 No 10WSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11.5.A Was Decedent Ever in U.S. Armed Forces 1
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BLUE CROSS BLUE SHIELD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VEY ပ 19b. Mailing Address (Street and Number or Rural Route Number, Pages 1 and 2 ment of Health a ant: If Item 27 is ury or other trau 303 HENDXICKSON NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State permit. Page: Department o Important: ff | any injury or 1.4.05 TOWSON, MARYLAND ANG HN C. GREENE FUNERALHM. Mt. OLIVE CHURCH GENETERY 5.4.05 `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BAGIMORE, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Eucephalopuhy Due to (or as a consequence of): Weeks /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, signois diverticulu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛄 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Tes 2 ₽No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Ø Other (Specify) s after death. 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital o within 24 hours aff To the Funaral DI 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MO 00061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles St Touson in 0 21204 660Z Jason Black 32. Registrar ignature 31. Date filed (Month, Day, Year) State 4 2005 Registrar

			1 - For State Registrar	State of Maryland	/ Department o		ental Hygien	ZIIII5 15026
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, La Decedent's Name (First, Middle, La Aa. Facility Name (If not institution, given	Dinkins	4b. City, Tov	m, or Location of Death	April 3	ay Year 3. Time of Death 2 0 2 0 4 10 PM c. County of Death
	Funeral Director		217-50-1090	Station Stender FOR Age (In yrs. last	ACAL BALL t birthday) Trunder Y Yrs. Months Di	ear II Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Year) 12-22-	9. Birthplace (State or Foreign Country). Florida
	ith the Maryland or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Baffi	10c. City, T	own or Location nda//			10d. Inside City Limits 1 □ Yes 2-71 No
	after death with the or Items 23a or 2:	Funeral Director	804 Peach O	rchard Lan 12. Was Decedent Ever in U.S.		1222		itizen of What Country?
5-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show calcul Executer must be retified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	1 □ Yes 2 1			Black, White, etc. Specify: Black
21215-	C 2 - 38	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)		16a. Decedent's Usual O (Give kind of work d life. DO NOT use re	one during most of worki etired)	ng	Kind of Business/Industry Warrhouse
and	2 should be filed within and Mental Hygiene. Is marked othar than aumatic evant, Ire M	To Be C	17. Father's Name (First, Middle, Last Joseph 19a. Informan's Name/Relationship (layton		18. Mother's Name Berhic		-ins
ore, Maryl	es 1 and 2 sho of Health and f itam 27 is my r other traum		Regina Poule- 20a. Method of Disposition	Dinkin Wife 20b. Plac	a of Disposition (Name of etery, crematory or other	L Orchard	Lane a	or Town, State, Zip Code) Location - Gity of Town, State
Baltimor	permit. Pages 1 a Department of Hes Important: If itam any injury or othe		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	(row	1	ddreas of Fibrilly	6 2005 An	al Service P.A. . led. 21217
	rhysician		23a. Part1. Enler the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that aused the death. It one cause on each line.	Do not enter the mode of	dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death United States
8760,	Medical Examiner hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialled events resulting in death) Last	b. Due to (or as a consequent of the	ace of): COMCE ace of): Common	21		years years
.O. Box 687	The law requires that the death certificate be executed the bas been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic pregn			23d. Date of delivery Month Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of the Con	contributing to death but not resulting to - intestmal	ng in the underlying cause	e given in Part I.	l la	use contribute to the cause of death?
		Completed	25. Was case referred to medical				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ō	ding Phys T. After this funeral di	tion: To Be	examiner? 1 Yes No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year) 28		the state of the s	ne 5 Residence 28d. Describe how inju	
Division	Jor afte Dira	Certification:	3 Suicide 6 Could not be determined		e, farm, street, factory, of	fice	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
	To tha Hospital or within 24 hours afte To tha Funaral Dirr completely filled in b	edical	(Check only 2 Medical Examone)	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	and/or investigation, in t	my opinion, death occurre	ed at the time, date ar	nd place, and due to the cause(s)
	To with	×	29b. Signature and title of certifier Association	Churce mS	29c. Lie	D-/829	8 41	ate signed (Month, Day, Year)
2	7/1/		30. Name and address of person who AUGUSTIN CHYU	3900 Lock Ray	Ba) (Type, Print)	D-1829 Bulliniere	, MD 21	218
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrate Signature	It house			

		-	For State Registrar	tate of Maryl		partment of H certificate of I			giene Reg. No. 🔿 🔿 💍) sine	
			Decedent's Name (First, Middle, Last)	_				2. Date of Dea			ime of Death
	Physicia		Salvatore Gr	eco				Month April	30 20	9ar	1:33AM
	/Medic Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or	Location of Death		4c. County of	Death	
	_xam.	•	Frederick Memorial	Hospital		Fre	derick	Frederick			
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthd	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9	Birthplace (State or Foreign
	Director		439-60-7586 ¹幫™	201	74 Yrs			Feb. 12	,1931	Italy	
	and *		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town o	r Location				10d. Ins	side City Limits
	Aaryla r sho	5	Maryland Frederick			_				1 []Yes 2⊠No
	28a-1	Funeral Director	10e. Street and Number		Mt. A	10f. Zip Code			10g. Citizen of Wha	at Country?	
	with		17194 Hardy Road			21771			U.S.	١	
	leath	era	11 Marital Status 12. V	Was Decedent Ever	in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-		American Inc	dian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Health and Mental Hygiene. Hitem 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event. It is Medical Examilitation at the multified at	by Fun	1 Never Married 2 Married	Armed Forces? I □ Yes 2 ★No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 25 No		Rican, etc.)	Specify	White, etc. White	
21215-0036	2 hou	bed	15. Decedent's Education	on	16a. De	ecedent's Usual Occup	ation		16b. Kind of Busin		
715	within 7% ene. than "nu	Completed	(Specify only highest grade co	mpleted) College (1-4or 5+)	- (G	ive kind of work done e. DO NOT use retired	during most of won d)	ang			
21	e filed withi Il Hygiene. othar than vent. Ine M	mo.	4		Sma1	1 Business			Retail		
nd	al Hy l oth	Be (17. Father's Name (First, Middle, Last)						Maiden Sumame)		
<u>la</u>	should be nd Mental marked o	10	Domenico Greco					Provenza			
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Type,	Print)		lailing Address (Street)
	1 and 2 Health em 27 i	ı ş	Rosa Greco (Wife)	12		94 Hardy R		Airy, M	aryland 2		tata
ore			20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Remo	oval from State		isposition (Name of crematory or other place	1				
altimore,	tmen tant:		`4 □ Donation 5 □ Other (Specify)	(Crestla			-2005	Marriotts	sville,	, MD
Bai	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	nkin		22. Name and Addre Witzke Fun 1630 Edmon	eral Home dson Ave.			Inc. 21228	8
			23a. Part1. Enter the disease or complicati shock, or heart failure. List only one c	ons that caused the ause on each line.	death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		oximate val Between
	Physician	2	Immediate Cause (Final disease or condition	Othan	selon	tic Care	liovasci	slav I	Disease	Unse	et and Death
	/Medical		resulting in death)	ue to (or as a co	nsequence of)	1,0					
7	Examiner		Saquentially list conditions, b	HYK	ert	ension				4	2 5
	be disit	iner	sayuaritany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence ot)						
	and -tran	Exami	that initiated events resulting in death) Last	Due to (or as a co	nsequence of)						
60,	ficate be executed physician and is the burial-transit	al E									
68760,	icate l physi s the b	edical	d								
_		/Me	IF FEMALE: 23c.	If yes, outcome of pi					23d. Date of	of delivery	
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	<i>'</i>		Month		Year
P.O.	at the de by the	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
	g g	by Pł	Part II. Other significant conditions contrib	uting to death but no	t resulting in th	ne underlying cause giv	en in Part I.	23e. Did to	obacco use contrib	ute to the cau	ise of death?
rds	quires in signi		Hyperlipi	denil				1 🗆 Y	fes 2□No 3	Probably	4 JUnknown
of Vital Records,	w require s been si should b	Completed	Diaber	La. 11/	Mit			24a. Was	an 24b. We	re autopsy fir	ndings available on of cause of
Re	The lav	lwo						autop perfor	rmed? dea	th?	٠.
ta		O	25. Was case referred to medical				26. Place of Dea				
Ξ	S D	0	examiner? Nes 2 □ No	oital:	2 KER/Outp	atient 3 DOA	ner: 4 🗆 Nursing H	ome 5 Resid	dence 6 Other	(Specify)	
	ding Ph h. After th funeral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye	ar) 28b. Tim		y at rk?	28d. Describe h	now injury occurred		
Ö	andir ath. or: Af	atic	2 Accident investigation			M 1	Yes 2 □ No				
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, fam pecify)	, street, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural Rou	te Number,
	ital o										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier (Check only one)	an: To the best of m On the basis of exa and manner stated.	y knowledge, o mination and/o	death occurred at the time investigation, in my of	me, date and place ppinion, death occu	, and due to the or rred at the time, or	cause(s) and mann date and place, and	er as stated. I due to the c	cause(s)
	To the To the To the Comp	M	29b. Signature and title of certifier	1) 1		29c. Licens			29d. Date signed (
	51		alem	Koler	est	W D.	5/17		5 - 3	-20	005
,	0		30. Name and address of person who comp	leted cause of death	(Item 23a) (T	ype, Print)	the	, -	5-3 derick,	1.5	- 1
1	0		Han Kohrer	(MD)	150	Vesto Co	Stoce	troc	derick,	MO	11701
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registratis	Signature	M Sparke	y		/		
	101	1	1971 Set 1 17 2	MAN TO A POST OF THE PARTY OF T	_~	APP					

		1 - State Registrar		of Mar	yland / Depa <i>Ce</i>	artment of H rtificate of I			iene 9. No A A	lon,	15020
Physicia		1. Decedent's Name <i>(First, Midd</i> Elizabeth Ra	,,	ett				2. Date of Death Month April	Day	Year 005	5. Time of Death 5:05A M
/Medic Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of Death		4c. County o		3.0311
	d	Charlestown Ca	re Center	_	In um In at histhefaul	Catons If Under 1 Year		O Date of Birth	Baltimore		
Funeral Director		5. Social Security Number 219–40–6696	1 ☐ M 2 🔀 F	7. Age (/	n yrs. last birthday) 90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 15	,1915	Gound Mary	
/land		Usual Residence of Decedent 10a. State 10b. County	,	1	0c. City, Town or Lo	ocation				10	0d. Inside City Limits
Man a-fsh iffed	tor	Maryland Balt	imore		Caton	sville					1 ∐Yes 2Ã No
or 28	Director	10e. Street and Number				10f. Zip Code		10	og. Citizen of W	hat Coun	try?
s 23a	rall	717 Maiden Cho		St21		2122			144.5	U.S.	
be titled within 72 hours after death with the Maryland atal Hygiene. Ad other than "natural", or items 23s or 28s-f show event, the Maryleaf Ext. after restification.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorce	If Yes. (Forces? 2 ⊠ No Sive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√2 No	ispanic Origin? (S) in, Mexican, Puerti Specify:	pecity Yes or No- o Rican, etc.)		, White, e	
2 hou	ted	15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of Bus	Whi iness/Ind	
2 should be filed within 7 and Mental Hygiene. Is marked othar than "n aumalic evant, If e M. d.	Completed	(Specify only higher Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of wor f)	king	Medic	ine	
e filed I Hyg othar	a	17. Father's Name (First, Middle,					18. Mother's Nam	ne (First, Middle, N			
should be nd Mental marked o	To B	William Peter	Rausch				Celeste	Bertha F	leinz		
permit. Pages I and 2 should Department of Health and Men Important: If item 27 is marker any injury or other traumatic. DRE.	Ċ	19a. Informant's Name/Relation:				ng Address (Street					
1 and 1 Health am 27 ther tr		W. Howard Garr	ett (Son		1317 20b. Place of Dispo	Cedarber	ry Court		tsville		
Pages net of t		1 ☑ Burial 2 ☐ Cremation		n State	cemetery, crea	matory or other plac	1			•	
artme ortani injury		' 4 □ Donation 5 □ Other (3			Druid Ric	2. Name and Addres	ss of Facility		Baltimor		aryland
permit. Departr Imports any inju		V/Cn	NO	n []	/// W:	itzke Fun 30 Edmon	eral Home	e of Cato	nsville	n In	228
200		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	10.49-2240		ng_noin	shoop	in			_	Onset and Death
/Medical Examiner		resulting in death)	Due	(or as a c	onsequence on:						7
xamiiio	-	Sequentially list conditions, if any, leading to immediate	b. Cerc		J VOSCE	you ac	ciden	†		- 6	rwaths
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<	(3.00							
exect an and rial-tra		resulting in death) Last	Due to	o (or as a c	onsequence of):						
icate be executed physician and sthe burial-transit	edicai		d								
		IF FEMALE:							1		
eath certifi attending	Physician/M	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal death 3	Ectopic pregnancy			23d. Date Mont		ry Day Year
t the de by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unk	gnant at tim nown	ie or death 5L	Other (specify)					
res that the igned by be detact	by Ph	Part II. Other significant conditi	ons contributing to	death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contrib	oute to th	e cause of death?
w requires been sign should be								1 □ Ye	s 2□No 3	Proba	ably 4 Unknown
e law re has bee	Completed							24a. Was ar	24b. W	ere autop	osy findings available of
The ate has page	Com							perform	ne <u>d</u> ? de	ath?	2 No
sician: Th certificate rector, pag	Be (25. Was case referred to medica examiner?						th (Check only one	3)		
ding Physician: The h. After this certificate h. funeral director, page	To	1 Yes 2 No		Inpatient	2 ER/Outpatier		4 Nursing H	ome 5 Resider)
ding F h. After funera	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	(h A-	e of Injury onth, Day Y	ear) 28b. Time o	Worl	Yes 2 □No	28d. Describe ho	w injury occurre	3	
r Attender death	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	ce of Injury	- At home, farm, str			28f. Location (Str	eet and Number	or Rural	Route Number,
s after	Serti	4 Homicide	buil	ding, etc. (Specify)			City or Town,	, State)		
To the Hospital or Attending Physician: The law requires that the death certification is 4 hours aftered principles of the theorem Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of n basis of ex inner stated	camination and/or in	h occurred at the tin vestigation, in my op	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and man ite and place, ar	ner as sta nd due to	ated. the cause(s)
To th To th	¥	29b. Signature and title of certific	ər			29c. License	e number	29	d. Date signed	(Month, L	Day, Year)
1		Thefar	_/			D 30		A	pril 3	0 2	2005
10		30. Name and iddress of person	who completed ca	use of deat	h (Item 23a) (Type,	Print)			T		
l"		Myla M Our	penter	MO	M IIF	iden C	noice L	v Costo	reville	2 1	S
Sta Registr		31. Qae filed (Month, Day, Year	0 4 2005	- Contract of the contract of	th (Item 23a) (Type,	A TONE					

			1 – For State Registrar	State of Ma	aryland		artment rtificate			and M	F	Reg. No. 2 (105	15030
	Physici	an	1. Decedent's Name (First, Middle	Lasi) H GRE	FFN	E					2. Date of Dea	Day	Year	3. Time of Death? U
	/Medic		4a. Facility Name (If not institution,				4b. City,	Town, or	Location o	f Death	APRIL	4c. County of Death		
п	LAGIIII		NORTHWEST HOSP	ITAL CENTER			RAN	DALL	STOW	V		BALT	IMOR	E
	Funeral Director		5. Social Security Number 057-01-5292 Usual Residence of Decedent	6. Sex 7. Ag 1	e (In yrs. Ia 91	st birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birtl	7913	9. Birth Cou	place (State or Foreign intry) NY
	yland yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	e Mar Ba-f sl	Director	MD N,	/A		BALT	IMORE							1 X Yes 2 No
	ath with the Marylan s 23a or 28a-f show usi to ruffiled at		10e. Street and Number	CUTC AVENUE			10f. Zip	Code	2121	E		10g. Citizen of \	What Cou	intry? USA
	death ms 23	Funeral	5833 PARK HEIO	12. Was Decedent	Ever in U.S	. 13.	Was Deced	ent of His			ecify Yes or No- Rican, etc.)	14. Rac		ican Indian,
920	72 hours after death with the Maryland neturel', or items 23a or 28a-f show disul Evart art must be rudified at	by	1 ☐ Never Married 2 ☐ Marri 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	No		ntYes,spec 1 □ Yes 2		Specify:	, Puerto	Hican, etc.)	Specify	ck, White	, etc. WHITE
2-0	72 hours "neturel",	eted	15. Decedent (Specify only highes			(Give	dent's Usua kind of wor	k done d	urina most	of work	ing	16b. Kind of B	usiness/li	ndustry
21215-0036	l within liene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		O RET	,				NEWSPAF	PER	
Maryland	od ala	To Be	17. Father's Name (First, Middle, L HENRY	.ast)		GREE	NE		18. Mothe		(First, Middle,	Maiden Suman	ne)	SCHINDLER
	d 2 sh h and 7 is m treum		19a. Informant's Name/Relationsh GEORGE GREENE			300	FIRST	AVE	NUE #	∮9-G		r, City or Town, VYORK,		10009
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 X Removal from State		nce of Dispo						20c. Location -		
Iţim	- E #		' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		STAF						0/2005 L LEVIN			ERDALE, FL
Ba	Depa Impo any in		Roll Solver	NOTISEE TO SEE THE PROPERTY OF										MD 21208
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of limits and list of the control of the contro	only one cause on each lin	10.	Do not ent			, such as	cardiac (or respiratory ar	rest,		Approximate Interval Between Onset and Death
ï	/Medical Examiner		resulting in death)	Due to (or as			mon	10	RE	nse	- INSU	PPICI G	uis	Morny
	hed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):					enosis			YEARS
× ´	le be executed /sician and e burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as			C 14 (<i>- /</i> 1	100	300				705
8760,	ate be hysicia the bu	llcai		d								<u>-</u> -		
Box 6	death certifica attending ph d for use as th	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Da	te of deliv	rery
P.O. B	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 4∏Pregnant at 9☐Unknown			Ectopic pre Other (spe					Mo	nth	Day Year
Vital Records, P	quires that n signed t ald be det	by	Part II. Other significant conditio	GASTOZO IN		•					23e. Did to		ribute to t	the cause of death? bably 4 Donknown
900	aw requir as been si 2 should	ompleted									24a. Was a	an 24b.	Were aut	opsy findings available
- Re	The ate h page	Com									autop: perfor 1 Yes	med?	death?	ompletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or			
of	Phys this al dii	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 2	R/Outpatier 28b. Time of		A Curio Bc. Injury Work			me 5 Resid			fy)
ion	Attending I r death. ector: After by the funer	atlor	1.☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation	y Year)	Injury	М		? ′es 2 □ n	No				
Division	E Sign	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of Injuring, etc	c. (Specify)				# # I		City or Tow	n, State)		al Route Number,
	To the Hospitel or Al within 24 hours after To the Funerel Direc completely filled in by	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the best examiner: On the basis of and manner sta	of my know examination	ledge, death on and/or in	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the c	ause(s) and ma late and place,	inner as s and due t	Day, Year)
	within To th compl	Me	29b. Signature and title of certifier	- 2 - 1	14 . 0		29c.	License	number		2	29d. Date signe	d (Month,	Day, Year)
)			> Kkong	argrer	140		DE	542	188			Apric	1 30	014005
	10		30. Name and address of person v	who completed cause of d	eath (Item 2	23a) (Type,	Print)	wes	- Ho	spi	las Cer	its		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 4	2005 32. Jegistra	ar's Signatu	1 1	are							

Funeral Director 5. Social Security Number 5.78 24 1868	Frederick Calvert If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) Washington I	M
Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Calvert Memorial Hospital Prince	Location of Death Frederick If Under 24 Hrs. Hours Min. Dec 4, 1923 As being the process of Birth (Month, Day, Year) (Month, Day, Year) Washington I (Month, Day, Year) (Country) 10d. Inside City Lin 1 Yes 20	
Director Social Security Name Social Se	Hours Min. (Month, Day, Year) Dec 4, 1923 Washington I 10d. Inside City Lin 1 Yes 20 10g. Citizen of What Country? United States	eign
	1 □ Yes ¾D 10g. Citizen of What Country? United States	DC_
Maryland Calvert Solomons 106. Street and Number 107. Zip Code	10g. Citizen of What Country? United States	
10f. Zip Code	88 United States	(NO
P.O. Box 366	14 Dans American Indian	
Maryland Calvert Solomons Maryland Calvert Solomons 10f. Zip Code	spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) Specify: 14. Race - American Indian, Black, White, etc. Specify: White	
The state of the s	ation 16b. Kind of Business/Industry	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occups (Give kind of work done of life. DO NOT use retired, 12 15b. Decedent's Education (Specify only highest grade completed) 16c. Decedent's Usual Occups (Give kind of work done of life. DO NOT use retired, 12 Retired Retai)	
To set a to	18. Mother's Name (First, Middle, Maiden Sumame)	-
Walter Goodwin	Frances Hancock	
Tr. Father's Name (First, Middle, Last) Walter Goodwin 19a. Informant's Name/Relationship (Type, Print) Mary Beth Goodwin (Wife) P.O. Box 366	and Number or Rural Route Number, City or Town, State, Zip Code) , Solomons , Maryland 20688	
Mary Beth Goodwin (Wife) P.O. Box 366 20a. Method of Disposition 1 Burial 2XXX remation 3 Removal from State 1 Burial 2XXX remation 3 Removal from State		
20a. Method of Disposition 1 Derivative Service Licensee 20b. Place of Disposition (Name of cametery, crematory or other place) 1 Derivative Service Licensee 20c. Method of Disposition 1 Derivative Service Licensee 20c. Method of Disposition 1 Derivative Service Licensee 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery)	y 6, 2005 Clinton, Maryland sof Facility Lee Funeral Home, Inc. 6633	Id.
21. Signature of Funeral service (consee	a Ferry Road, Clinton, Maryland 2073	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	g, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death	
Physician Medical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	URE	
Examiner Sequentially list conditions. b. Remark For Durke	-	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	2 CANCOR	
that initiated events c	- CANCER + FA LURF	
CONSOSTING THE CONSOSTING OF STREET	1 Month	
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in the underlying cause divided to the cause (Disease or injury that initiated events resulting in the underlying cause divided to the cause (Disease or injury that initiated events resulting in the underlying cause divided to the cause (Disease or injury that initiated events resulting in the underlying cause divided to the cause (Disease or injury that initiated events resulting in the underlying cause divided to the cause (Disease or injury that initiated events resulting in the underlying cause divided to the cause (Disease or injury that initiated events resulting in the underlying cause divided to the cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated events resulting in the underlying cause (Disease or injury that initiated ev	23d. Date of delivery Month Day Year	
Part II. Other significant conditions continuously to death but not resulting in the discontinuity seaso give	en in Part I. 23e. Did tobacco use contribute to the cause of death	
The law are has the page 2 s page 2 s	24a. Was an autopsy performed? 1 \(\text{Yes} \) 24b. Were autopsy findings avail prior to completion of cause death? 1 \(\text{Yes} \) 24b. Were autopsy findings avail prior to completion of cause death? 1 \(\text{Yes} \) 24b. Were autopsy findings avail prior to completion of cause death? 1 \(\text{Yes} \) 24b. Were autopsy findings avail prior to completion of cause death? 1 \(\text{Yes} \) 24b. Were autopsy findings avail prior to completion of cause death? 1 \(\text{Yes} \) 24b. Were autopsy findings avail prior to completion of cause death?	
25. Was case referred to medical examiner? 1	26. Place of Death (Check only one) er: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
4 Sign of the state of the stat	y at 28d. Describe how injury occurred	
To the state of th	Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number,	
27. Mannar of Death 1	City or Town, State)	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tire (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my or and pages of the pages of the pages.	pinion, death occurred at the time, date and place, and due to the cause(s)	
et of the state of	e number 29d. Date signed (Month, Day, Year) 05/02/2005	ħ
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUNUT WRUNK HOTOSpital ROWA	Prince Frodorick MD 20678	
State Registrar 31. Date filed (Month, Day, Year) NAY 0 4 2005 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Maryla		tificate of			giene _{Reg. No.} 2 (005	15032
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Westor	Grego	ry			2. Dete of De Month	Day _	Year 2005 4	Time of Death
	Examin Funeral Director	er		sing H	STILL S. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bin (Month, Da	th y, Year)	9. Birthplace Country)	(State or Foreign
	ō		187 – 01 – 1533 Usuel Residence of Decedent 10a. Stete 10b. County		City, Town or Loc	ation		12/3	1/1918	Unkno	nside City Limits
	the Maryls 28a-f sho	Director	MD Baltimor 10e. Street end Number		arkville				10g. Citizen of \	1	☐ Yes 2, 🖾 No
020	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiena. Item 27 Is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examener must be notified at	by Funeral Di	8710 Emge Road	12. Was Decedent Ever in l Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Yeer or Dates:		21234	Hispanic Origin? (S an, Mexican, Puert Specify:		United	States ce - American Ir ck, White, etc.	
21215-0020	filed within 72 hou Hygiena. other then "natura ent, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16e. Deced (Give I life. D		pation during most of wor d)	king	16b. Kind of B	usiness/Industr	у
Maryland 2	2 should be filed and Mental Hyg la marked other raumatic event,	To Be C	17. Fether's Neme (First, Middle, Last) Unknown Unknown		United		18. Mother's Nar			ne)	
	Pages 1 and 2 sho ient of Health and rit: If Item 27 la m iry or other traum		19a. Informant's Name/Relationship (Ty) Stephanie Goldstein 20a. Method of Disposition 1 □ Burial 2 □ Peremation 3 □ Relation	/ Worker	8710	Emge Ro	and Number or Ru ad Parkvi ce)				
Baltimore,	parmit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to page.		4 □ Donation 5 □ Other (Specify) 21. Signature ■ Funeral Servi ➤ License		984 c	Name and Addre	tory Inc. ess of Facility and Funer n Pastures	. 2005 al Alter	natives	ille, Ma	ryland land 2128
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Ceuse (Final disease or condition resulting in death)	Cardi	ath. Do not ente	Arrhy		or respiratory ar		App	roximate roximate roxal Between ret and Death
68760,	icate ba axecuted physician and s the bunal-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitleted events resulting in death) Lest		or as e consequ						
P.O. Box	iat the daath certit d by the attanding letached for usa a	Physician/M	Part II. Other significant conditions confirmed and the significant conditions	0 -	-		ven in Part I.		obecco use col	ntribute to the	cause of death?
of Vital Records,	The law requiras ate has been sign page 2 should be	Completed by	Urinary 7	Parano	ufact	ron			an autopsy med?	availabl comple of death	utopsy findings e prior to tion of cause 1?
Vital		o Be C	25. Was case referred to medical examiner?	ospitel:	7.50/0.4-4	oll post Oth	26. Place of Dea	th (Check only o	ne)	1	
	Attending Physician: or death. ector: After this certific. by the funeral director,	- 1	27. Menns of Death 1 Inaturel 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		ome 5 Resid	ience 6 ⊔Oth now injury occurr		
Division	를 를 들	edicai Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Special and Injury - At I building)	ify)		me data cod di	City or Tow			
	To the Hospital within 24 hours a To the Funeral completaly filled	Medica	29a. Certifier (Check only one) 1	er: On the best of my known: On the basis of examination and manner steted.	owiedge, death etion and/or inve	estigation, in my c	ppinion, death occu	rred at the time, o	cause(s) and madate and place,	and due to the	cause(s)
	W -		· Orighin	Cow, un	m 22a) /Tr 7		905985 Ien Bli	L L	-//		
7	Stat	e	30 Mame end address of person who core (INGI) (IS) 31. Date-filed (Month, Day, Year)	MD 560 32. Registrar's Sign	1 loc	4 Ran	ien Blu	id, B	dimo	re MI	021239.

DHMH 16 Rev 6/95

			1 - For State Registrer	State of Maryla	nd / Depa		lealth and	Mental Hyg	iene	5 15022
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
	Physici		Helen M	ary Garrett				Month 04	Day 200	5 2:33a M
}	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Deat	4c. County of Death		
			Alfred House Elde	r Care		Silver	Spring		Mont	gomery
	Funeral		Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	B. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
ш	Director		198-18-8285	M 2000F 81	Yrs.		110010	03-29-1	924 P	ennsylvania
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	ocation				10d, Inside City Limits
	sho	5								1 Yes 2 No
	28e-f	Director	MD Montgome 10e. Street and Number	ry S	ilver S	10f. Zip Code		1	0g. Citizen of What	
	with		4 Broomall Ct.			Tot. Zip Code	20906	'	USA	Country
	be filed within 72 hours after death with the Maryland nat Hygiene. ed other then "naturel", or Items 23e or 28e-f show svent, the Modical Examinar court by norline 1 at	Funeral		2. Was Decedent Ever in t	U.S. 13	Was Decedent of H		Specify Yes or No-		merican Indian,
	in ten	F.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🖾 No	1	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		/hite, etc.
036	urs a	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	nation	deina	16b. Kind of Busine	ess/Industry
2	19	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired	d)	, any		
2	e filed within al Hygiene. I other then 'vent, Ine M.	Con	12		Hon	nemaker			Own Ho	ne
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last)	•				me (First, Middle, M		
<u>X</u>	should be and Mental s marked o	P_C	Vincent B. Morgan					Anna Lesk	•	
Maryland 21215-0036	12 sho		19a. Informant's Name/Relationship (Type Daniel V. Garrett	e, Print)	19b. Mailii 55 H			nbelt, MI	. City or Town, Stat 20770	e, Zip Code)
ത്	s 1 and 2 should if Health and Mer item 27 Is marke other treumatic		20a. Method of Disposition	20b.	ADDA.				20c. Location - City	or Town State
סָר	ages if it		1 Burial 2 ☐ Cremation 3 ☐ Re			osition (Name of matory or other place National		04-2005	Laurel,	
Baltimore,	rtent rtent		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Alpease			National 2. Name and Addre		04-2005	Laurer,	FID
Ba	permit. Pages Department of Himportent: If ite any injury or of once.		- CAN (1 41)		can -	Rapp Fun	eral &_C	remation.	Service ng MD 20	21.0
	_		23a. Part1. Enter the disease, or compli		ath. Do not ent	933 Gist	Ave, S1	Lver Spri	ng MD 20	Approximate Interval Between
	Editor:		shock, or heart failure. List only on immediate Cause (Final	e cause on each line.						Onset and Death
	Fnysician /Medical		disease or condition resulting in death)	Cerebro Due to (or as a conse		Lar Accid	ent			3 Months
	Examiner					c Dement	ia			6 Months
		ē	Sequentially list conditions, in any, sading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a conse						
	d d ansit	Examiner	Cause (Disease or injury that initiated events	Arteri	osciero	sis				Years
o,	an an rial-tr	EX	resulting in death) Last	Due to (or as a conse						
68760,	death certificate be executed e attending physician and nd for use as the burial-transit	ical	d							-
	leath certificat attending phy I for use as th	Med	IF FEMALE:							
Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
	it the dea by the at tached fo	Physiclan/Med	1 Yes 2 No	4□Pregnant at time of 9□ Unknown	death 5	Other (specify)			MOUTH	Day 16a1
P.0	The law requires that the ate has been signed by th bage 2 should be detache	Phy	Part II. Other significant conditions con	tributing to dooth but not ro	culting in the u	adarhina agusa air	on in Bort I	23e Did tob	acco use contribut	e to the cause of death?
è,	uires ti signe	by	Partin. Other significant conditions con	mouting to death but not re	isaliting in the a	riderlying cades giv	Garatta			Probably 4 TUnknown
Records,	w requ	Completed								
3ec	The law cate has l page 2 s	ldm						24a. Was ar autops perforn	y prior	autopsy findings available to completion of cause of
al F								1 ☐ Yes 2	!₩ No 1□	
Vital		Be	25. Was case referred to medical examiner?	ospital:	7.55.0	Oth		ath (Check only on		Retirement
*	Phys this ral di	To To	1 ☐ Yes 2 ₹ No 27. Manner of Death	1 Inpatient 2L	ER/Outpatier 28b. Time o				nce 6 Mother (S w injury occurred	Retirement Home
DO	ding h. After fune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □ No	300. 5000.00	injury occurred	
Division	Atten deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At I	home, farm, str					Rural Route Number,
Ē	after Dire	Certification:	4 Homicide	building, etc. (Spec	rify)	,,,		City or Town	, State)	
	spite		29a. Certifier 1 € Certifying Phys	icien: To the best of my kn	owledge, deat	h occurred at the tir	ne, date and place	e, and due to the ca	luse(s) and manner	as stated.
	ne Ho n 24 l ne Fu	Medical	(Check only 2 Medical Examination)	er: On the basis of examinand manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	irred at the time, da	ate and place, and	due to the cause(s)
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: Attent completely filled in by the funera	ž	29b. Signature and title of certifier	/ances	1	29c. Licens		25	9d. Date signed (M	
)			Delines)	- Care CEDA		D2	5410		04-28-2	JUS
1	1/		30. Name and address of person who co-							
(/	42	Oliver Lawless 1	8111 Prince	Phillip	Dr. Oln	ey MD 20	832		·
	Sta Registi		31. Date filed (Month, Day, Year)	0 4 32005 strar's	ature	5 Agood	Ī			

			Please 1 - State Registrar		aryland / Dep	ndelible Ink. partment of He e <i>rtificate of D</i>	ealth and Mo	•	ne 2005	15031
	Physici /Medio		Decedent's Name (First, Middle, L Harold Raymond					2. Date of Death Month	Day Yeer 30 2005	8:45a
	Examir		4a. Fecility Name (If not institution, gi			4b. City, Town, or I			4c. County of Dea	
			Independance Co 5. Social Security Number 6.		ge (In yrs. last birthda	Hyattsv		8. Date of Birth	Prince	
ļ	Funeral Director		337-12-3283 Usual Residence of Decedent	1 3 tM 2□F	84 Yrs.	Months Days	Hours Min.	(Month, Day, Ye 12-04-1		irthplace (State or Forei Country) 111inois
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit
	Mar a-1 sl	iç			Washin	gton DC				1⊠Yes 2□N
	ith the)ire	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What C	ountry?
	ath w	rai	222 8th St. NE				0002		USA	
USO	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-1 show re Mcdical Exeminar nust be published	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates:	No 1940 1960	3. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No	spanic Origin? (Spenic Arguments of Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or	5+) (Gi	cedent's Usual Occupative kind of work done du b. DO NOT use retired)	uring most of workin	168	b. Kind of Business	•
V	filed wi Hygien other th	Con		4+	Fo:	reign Offic			Goverme	nt
yland	should be fill not Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Las Theodore Griffi					Mae Stock	s Griffi	
Mar	and s m		19a. Informant's Name/Relationship			iling Address (Street ar				Zip Code)
	s 1 and 2 of Health item 27 i	1 8	Richard E. Down	ing (steps		22 8th St.				Taum State
saitimore,	iges 1 it of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, c	rematory or other place)		c. Location - City o Beltsvill	
	it. Partmer		* 4 ☐ Donation * 5 ☐ Other (Spec 21. Signature of Funeral Service Dice	**	Chesapea	ake Cremato 22. Name and Address		05 1	eitsviii	e, m
מ	permit. Pages Department of f Importent: If its any injury or or	Ĺ	· CALICAUI	mann H	100382	Rapp Funera 935Gist Ave	al and Cr	emation S	Services MD 20910)
00,	Physician /Medical Examiner parial-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 121, 132 in 112 in	a. CHROADue to (or as		BSTRUTIU	e Lund	Ce Dise	A8 E	Interval Between Onset and Death
-	icate be physicl s the bu	licai		d						
.O. BOX 68	death certif e attending ed for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death	B Ectopic pregnancy Discrete (specify)			23d. Date of de Month	elivery Day Year
7	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	•		, , ,	n in Part I.	23e. Did tobac	co use contribute !	to the cause of death?
cords,	aquire an sig	ed t	BENIGN YN	OSTANC	Hupsemo	PHY		1 🗆 Yes	2 □ No 3 1	Tobably 4 Unknow
ecc	law requas been 2 should	Completed	HEPERTENS10	N				24a. Was an autopsy	24b. Were a	autopsy findings availab completion of cause of
r	The lav	No.	ALZHEIMER	1c DE	MENTIN			performed 1 ☐ Yes 2 🔀	d? death?	_
Vitai	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
Ö	ng Phys fter this ineral di	P	1 Yes 2 No 27. Manner of Death 1 Actival 5 Pending investigation	28a. Date of Inj (Month, Da	ent 2 ER/Outpat ury 28b. Time ay Year) Injun	of 28c. Injury Work	at 2	ne 5 Residence 8d. Describe how i	e 6 Other (Speinjury occurred	ecify)
DIVISION	Hospitel or Attending 14 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not determine	289. Place of th	jury - At home, farm, tc. (Specify)	street, factory, office	2	8f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying F	Physicien: To the best eminer: On the basis of and manner s	of examination and/or	ath occurred at the time investigation, in my opi	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and du	is stated. le to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	Hes Su	guer is	29c. License		29d.	Date signed (Mon	onth, Day, Year)
	M.		30. ame and address of person	co leted cause of	ath (Item 23a) (Typ	e, Print)		NO. 005		
	' '	-	Francine Higgs	-Shipman 1	1700 Belts	ville Dr. 1	Beltsvill	e MD 2070	J5	
	Sta Regist		31. Date filed (Month, Day, Year)		rar's Signature	u land	,			
DH	IMH 17 Rev 1/2		MAY	U 4 ZUU5	Blown L	1 Sporte				
				*						

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State	State of Mar	-	artment of F		ind M		giene Reg. Noi	2001	5 15035	
			1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Co. Year 3. Time of Death				
	Physicia /Medic	al	Perfecto		nandez								
	Examin	er	4a. Facility Name (If not institution,	201 E. Unj	.v.Pkwy	4b. City, Town, o					County of D		
			Union Memoria 5. Social Security Number 6		- (In yrs. last birthday	Balti						nore City Birthplace (State or Foreign	
	Funeral Director		124-16-2825	1X XM 2□F 7		Months Days	Hours	Min.	8. Date of Bird (Month, Date 4 — 7 — 1	927	P	Birthplace (State or Foreign Country) uerto Rico	
	D		Usual Residence of Decedent		100 City Town and							10d. Inside City Limits	
	show	Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Insid										
	28a-f		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								21		
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Heatile and Mental Hygiene. And arment of Heatile and Mental Hygiene. Thatural; or items 21 a narked other than "natural; or items 23 a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at injury or other traumatic event, the Medical Examinar must be notified at ag.		239 East 115t	h Street		10029)			USZ	A		
			11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13	Was Decedent of I	lispanic Orig	gin? (Spe . Puerto f	cify Yes or No	-	14. Race - A Black, W	merican Indian, /hite. etc.	
õ	or ite		1 Never Married 2 Marrie	d 1 ☐ Yes 2 ☐ No If Yes, Give X		Yes 2□ No				1			
Maryland 21215-0036	hours tural',		3 XWidowed 4 □ Divorced	Year or Dates:	16a Dec	edent's Usual Occu					ind of Busine		
<u>.</u>	n na		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Gleve kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bit (Gleve kind of work done during most of working life. DO NOT use retired)							,			
717	r than	mox	Elementary/Secondary (0-12)	College (17401 54)	Dist	tributer	,				ıck		
B	be filed ital Hygi ed other event,	Be (17. Father's Name (First, Middle, La Simon Hernand				1		(First, Middle, Torre		Sumame)		
<u>X</u>	Meni Meni Marken	T _o			10h Mai	ling Address (Street					r Town State	e Zin Code)	
<u> </u>	d 2 st th and th and traun traun		19a. Informant's Name/Relationshi Ebony Sutton			4 Madisc							
	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Disp	oosition (Name of ematory or other pla	ce)	D	ate	20c. Lc	ocation - City	or Town, State	
e E	Pages nent of ant: If it ury or o		1√ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		St. Ray	ymond Ce	m !	5-4-	2005	Bro	ax, N	Υ.	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Li	DAUDOC S	1	22. Name and Addr New York	Mor	tuar					
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that caused to	he death. Do not e	nter the mode of dy	ng, such as	cardiac o	r respiratory a	rrest,O]	ck, N	Y - 10029 Interval Between	
	Physician /Medical Examiner special transit		Immediate Cause (Final disease or condition		bleevie							Onset and Death	
			resulting in death)	Due to (or as a	consequence of):							\ J. H.	
		Examiner	Sequentially list conditions,	vhaze							- montu		
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			۳).						> 7mont	
											> Imonthe > 7month unknown		
		cail		d_colon	colon cancer							unknown	
9			IF FEMALE:										
ROX	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal death 3	□Ectopic pregnanc	У				23d. Date of Month	delivery Day Year	
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at ti 9 □ Unknown	ime or death 5	Other (specify) _							
Δ.	that the ded by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?			e to the cause of death?		
Records,	quires n sign ald be	d by							Yes 2	2 No 3 Probably 4 Unknown			
000	The law requires that the death certifica isate has been signed by the attending pheage 2 should be detached for use as the	Completed							24a. Was		prior	autopsy findings available to completion of cause of	
Re		mo:							perfo	rmed? 2 \(\square\) No	death	h? 🔪	
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					of Death	(Check only	one)	·		
of <	Physician: this certific ral director,	2	1 Yes 2 No	Hospital: 1 Inpatien		ent 3 DOA			me 5 Res			Specify)	
		lon	27. Manner of Death 1 Natural 5 ☐ Pending		Year) 28b. Time Injury	, Wo	ork?]Yes 2.□		28d. Describe how injury occurred				
Division	Atten r deat octor: by the	ficat	2 Accident 3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, fa							28f. Location (Street and Number or Rural Route Number,			
2		Certification;	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)										
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in the completely filled in the complete of the	Medical C	29a. Certifier (Check only (Ch								r as stated. due to the cause(s)		
	o the o the omple		one) 29b. Signature and title of certifier	and manner stat	160.	29c. Licer	se number			29d. Da	te signed (M	lonth, Day, Year)	
)	F ≱ F 8		> ashinta	29c. License number 29d. Date signed (Month, Day, Year) ATZY 38946 E17 4/29/06									
A	1		30. Name and address of person v	who completed cause of de	eath (Item 23a) (Typ	e, Print)		r 4 1	2 4	-1	- 11		
\prec			Allan Hunte	MID SW	aath (Item 23a) (Typ Ur's Signature	nion W	lwn i	21	tospih	1	Balh	more mo	
		ate	31. Date filed (Month, Day, Year) MAY 0 4	2005 Registra	r's Signature	sell!			•				
	Regist	Tdf	mini 0 2	LOUS JENESSES	~ 7								

		1	State of Maryland / Dep	artment of Health and M rtificate of Death		ene 0 0 5	15036		
	9		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death		
	Physicia	4	John Edward Hoerl		April				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
			526 Ingleside Avenue	Catonsville	l a n	Baltimo			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Jan. 22,	Year) 9. Birth Cour 1924 Mary			
	Director	-	218-18-5146 81 Yrs. Usual Residence of Decedent		Jan. 22,	11724 11419			
	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or Items 23e or 28e-f show avent, Ital Medical Eraminer must be notified at		10a. State 10b. County 10c. City, Town or L	ocation		1	Od. Inside City Limits		
		ctor	Maryland Baltimore Cator			1 □ Yes 2 No			
		Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou.	ntry?		
		ral	526 Ingleside Avenue	21228		U.S.A.	ean Indian		
36		by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give WW II Vear or Dates:	Was Decedent of Hispanic Origin? (Splf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White,			
21215-0036		ed b	15. Decedent's Education 16a. Dece	edent's Usual Occupation	. 1	6b. Kind of Business/In			
15		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)					
212	e filed within al Hygiene. I other than '	mo.		rvisor		altimore Ga	s & Elec.		
pu	should and Mer smarks	Be (17. Father's Name (First, Middle, Last)	aiden Sumame)					
Maryland		ဥ	John Hoerl	ling Address (Street and Number or Rur	ie Poehli				
Mar						11e, MD 212			
	of Health of Health itam 27 i		20b. Place of Disposition	position (Name of		0c. Location - City or T			
nor	Pages nent of I int: If its		1 ☑ Burial 2 □ Cremation 3 □ Removal from State MeadOWr1 1 ☑ Donation 5 □ Other (Specify)	ematory of other place) dge Memorial	-2005 E	Elkridge, M	arvland		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Witzke Funeral Hom	e of Cat	onsville, I	inc.		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	1630 Edmondson Ave	or respiratory arre	st,	Approximate Interval Between		
	Physician and physician and physician and physician and physician and the pnual-transit	9.1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gisease or condition)	1			Onset and Death		
			disease or condition resulting in death) Due to (or as a consequence of)						
Ų.		ner	if any, leading to immediate Due to (or as a consequence of):						
		Examiner	Cause (Disease or injury that initiated events c.						
90,	oe execian a		resulting in death) Last Due to (or as a consequence of):						
8760,	physic physic the t	dica	d						
O. Box 6	es that the death certif gned by the attending be detached for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown		23d. Date of delivery Month Day Year				
Records, P.		by	Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ∀nknown					
S	w requir been si should	Completed	Diabets		24a. Was ar				
Re	he la e has age 2	dwo	7 (000)		autopsy perform	hed? _ death?	death?		
Vital	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	a	25. Was case referred to medical 26. Place of Death (Check only one)						
Ž		To B	examiner? 1 Tyes 2 Too Hospital: 1 Inpatient 2 SER/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5 Reside	nce 6 Other (Spec	fy)		
n of		ü	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	/ Work?	28d. Describe ho	w injury occurred			
Sio		Certification:	2 Accident investigation	M 1 Yes 2 No	29f Leasting (Ct	(Street and Number or Rural Route Number,			
Division		Ė	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town	wn, State)			
		edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)						
	o tha	Med	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month			
	- SFO	1	STA MAD	D24170		May 2, 2	005		
	171		30. Name and address of person who completed cause of death (Item 23a) (Typ	1.	May 2, 2005 imore MD 21205				
_	10		E Tso MD Richey Hospice 838 A	JENTOW ST Bal	timore	MD 2120)5		
		ate	31. Date filed (Month, Day, Year) 32. Regitrar's Signature	Coarles					
	Regist	rar	MAY 0 4 2005 May 50	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrer Certificate of Death Reg. No. () 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 2, 2005 12:49P M Lucius S. Henderson, III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) Apr. 26, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 1937 North Carolina 577-50-2381 68 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "neturel", or items 23a or 28a-f show other traumatic event, If a Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Directo Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be tiled within 72 hours after death with 1 nent of Heatth and Mental Hyglene. Int: If item 27 is marked other than "neturel", or Items 23a or 2 20817 United States 9130 Fernwood Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1961- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: 1963 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ President Research Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grace Anderson 2 Lucius S. Henderson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi R. Henderson/Wife 9130 Fernwood Road, Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 7, ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) 2005 Rock Creek Cemetery Washington, D.C. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Mont omery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensie poce 2009 M00803 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Encophalo **Physician** disease or condition resulting in death) /Medical Due to (or as a const uence of): Examiner rulmon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause) Examine sicion and burial-transit law requires that the death certificate be executed Morcosula that initiated events resulting in death) Last to (or as a consequence of): ta anenea Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Diabote 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed 1 Yes 2 10 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 DInpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 T Homicide To the Hospitel or within 24 hours aft To the Funerel Di completely tilled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7867 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 4701 Randolph Road, Suite 101, Rockville, Maryland Oney Zuriga, M.D.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

o.

Records,

Vital

o

Division

ķ

2005 Registar's Signature

Joseph !

05**-**2988 B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrar 1. Decedent's Name (First, Middle, Last,		ertificate of Death	2. Date of Death		3. Time of Death	
Physici			Timothy Allen Hoe	se	APRIL 3	30,2005 Year	0930 A	
/Medic Examir		4a. Facility Name (If not institution, give 3216 NORMANDY WOO)		4b. City, Town, or Location of Death		4c. County of Deat HOWARD		
Funeral Director		5. Social Security Number 6. Se 215-92-0187	7. Age (In yrs. last birthda M 2 F 41 Yrs	Months Davs Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Fore	
, J		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Logotion	January 23	, 1904	Japan 10d. Inside City Lim	
e Maryla le-f shov	Director		ward	Ellicott City			1 🗆 Yes 2	
vith th	Dire	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co		
s 238	ral	3437 Dogwood Drive	12. Was Decedent Ever in U.S. 1	21042	nooity Voc or No-		U.S.A. 14. Race - American Indian,	
s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I Health and Mental Hygiene. I Health and Sae or 28e-1 show item 27 le marked other than "neturel; or Items 23e or 28e-1 show other traumatic event. The Maritial Examination of the rediffical and	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 XYes 2 No If Yes, Give 1982 Year or Dates: 2005	 Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify: 	o Rican, etc.)	Black, White		
in 72 hou n "neture	Completed	15. Decedent's Edu (Specify only highest grad	ication 16a. De (G (G (iff.	icedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	king	6b. Kind of Business/	Industry	
within piene. r than "	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Disability Examiner		0.3 G0	Verninent	
nd 2 should be filed withir lith and Mental Hygiene. 27 le marked other than r traumatic event, IIIs Ma	To Be C	17. Father's Name (First, Middle, Last) Walter	F. Hoese	18. Mother's Nam	ne (First, Middle, M	laiden Sumame) zuko Ueki		
should and Men marke	-	19a. Informant's Name/Relationship (7)		ailing Address (Street and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)	
and 2 salth a n 27 le		Ms. Valerie M. Hoese	Spouse	3437 Dogwood Drive Ellico	ott City, Maryl	and 21042		
permit, Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Di	sposition (Name of crematory or other place)	Date 2	Oc. Location - City or	Town, State	
Pages nent of I ant: If its ury or o	1	4 Donation 5 Other (Specify)	Marylan	d Veterans Cemetery - 05	5/06/2005	Crowns	sville, MD	
permit. Departr Imports any inju	1 8	21. Symature of Fundo Service License	84	2 Nowns wifiedness of Facility				
205 20		Mundelle-	le M00535	Slack Funeral Hom 3871 Old Columbia	Pike Ellicott	City, MD 2104	2	
			lications that caused the death. Do not ne cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate interval Between Onset and Death	
Physician	Œ (I	Immediate Cause (Final disease or condition resulting in death)	a. Jas	Ja ING				
/Medical Examiner			Due to (or as a consequence of):	3 1				
	Examiner	Sequentially list conditions, if any, leading to immediate	 Due to (or as a consequence of): 				-	
uted d ansit		Sequentially list conditions, if any, leading to immediate easts. Enter Underlying Cause (Disease or injury that initiated events						
ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):					
cate be ex physician a the burial	cal		d					
ntifica ng ph s as th	Med	IF FEMALE:						
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 Ectopic pregnancy 5 Other (specify)	- 410-size	23d. Date of del Month	ivery Day Year	
signed by	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
quires n sign					1 ☐ Ye	s ⊅0No 3□Pr	obably 4 Unkno	
or Attending Physicien: The law requires taler death. Silector: Atter this certificate has been signed in by the funeral director, page 2 should be a	Completed				24a. Was an		topsy findings availa	
The law te has age 2 (E O				autopsy perform Yes 2	ned? death?	completion of cause	
yeiclen: The is certificate hadirector, page	a	25. Was case referred to medical		26. Place of Dea	th (Check only one			
Physical this cer al direc	To B	examiner? XXYes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA Other: 4 Nursing H	ome 5 Resider	nce 6 XOther (Spe	city) AT SCE	
Attending Physiclen: r death, sctor: After this certific by the funeral director,		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 28b. Tim (Month, Day Year) Injury	e of 28c, Injury at your Work?	28d. Describe hor	w injury occurred	1 - (
eath. or: A	Certification:	2 Acident investigation	UNE UN	M 1 ☐ Yes 212 No	Subje	Tronge	great	
or Att	rtiff	Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	. 1 .0	28f. Location (Str City or Town,	eet and Number or Ru , State)	iral Route Number,	
d D			wo	odedorea	5216 MV	mandyle	Socks M	
urs ere		29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☑ Medical Exam	iner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	to the cause(s)	
Hospitel 24 hours a Funerel stely filled	1ica	one / Z	מוזע ווובוווסו אנמנסט.					
o the Hospita ithin 24 hours o the Funere	Medical	one		29c. License number		d. Date signed (Monti		
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medica	one	m	O.C.M.E		$MAY \ 1, \ 2005$		
To the Hospite within 24 hours To the Funere completely fille	Medica	one	completed cause of death (to = 200) To	O.C.M.E				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylar		artment rtificate			and M	lental Hyg	giene Reg. No.	2000	1	2.5
	Physicia	an	1. Decedent's Name (First, Middle,								2. Date of Dea Month	ath Lay	- U U O Year	3. Time o	Death
	/Medic			James Rob		ohnson					April	29	2005	1:45	A M
	Examin	er	4a. Facility Name (If not institution,				4b. City, T			of Death			ounty of Death		
H			Laurel Region 5. Social Security Number			last birthday)	If Under 1	aure	If Under	24 Hrs.	8. Date of Birt		ince G		
	Funeral Director		410-56-5265	1⊠M 2□F		57 Yrs.		Days	Hours	Min.	(Month, Day	у <i>Үөаг)</i> 8 193	7 Te	place (State of intry) nnesse	e.
			Usual Residence of Decedent												
	how		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside C	
	e Ma 3a-1 s	cto	MD Howard	l	I	Laurel								1 L Yes	2 No
	or 2	Director	10e. Street and Number				10f. Zip (10g. Citize	n of What Cou	intry?	
	s 23s	rai	9228 Whiskey Bo			10		2072			" V	144	USA	· I= 4:==	
	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Ford d 1XX es 2	es?	956-	If Yes, speci	ify Cuba	spanic Ori n, Mexicar	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	- 14	. Race - Amer Black, White		
5	hours after death with the Maryland lural', or Items 23e or 28e-1 show al Examiner must be notilied at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	_	958	1 ☐ Yes 2	∑ No	Specify:			s	pecify: Wh:	ite	
9500-612	J within 72 hours after death with the Maryian jien. r than "natural", or Items 23a or 28a-1 show the Modeal Examiner must be notilised at	ted	15. Decedent's	Education		16a, Dece	dent's Usual	Occupa	ition			16b. Kind	of Business/I	ndustry	
2	within 72 ene. than "nat	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	4or 5+)	life.	kind of work DO NOT use	k done d e retired,	<i>luring</i> mos)	t of worki	ng				
7	er th	Completed	10th	Ø		Mer	chand	iser	:			Prog	ressive	e Serv	ices
	be filed ntal Hygia ed other event, I	Be	17. Father's Name (First, Middle, La						18. Mothe	er's Name	(First, Middle,	Maiden Si	umame)		
<u>8</u>	Meni Meni arke	<u>م</u>	James Bascomb J								e Canno				
Maryland	es 1 and 2 should be fi of Health and Mental F f Item 27 is marked of r othar traumatic ever		19a. Informant's Name/Relationshi								A/Route Numbe	Ť			
25	1 and 1ealth sm 27 thar t		Patty Wynston/C	companion	20h	9228 Place of Dispo		_	Botte		oad, Lan		MD 20	0723	
altimore,	if it		1 🖾 Burial 2 ☐ Cremation 3		tate	cemetery, cre	matory or oth	her place	-						
	it. Partmer rtant rtant		* 4 ☐ Donation 5 ☐ Other (Special Service Li		MD	Vetera				5/4/:	naldson		nsville		7
g	permit. Pages 1 Department of H Important: If Ite any Injury or oti once.		21. Signature of Turierar Service E	100 1	M01103					-	, Laure			•	
			23a. Part 1. Enter the disease, or c	omplications that car	used the dea									Approxima	te
	Physician		shock, of heart failure. List of Immediate Cause (Final			stic Tu	na Car	n a o r						Interval Be Onset and	
	/Medical		disease or condition resulting in death)	a	r as a consec	atic Lu guence of):	ing ca	ncer							
	Examiner		O THE PARTY OF THE		OPD								9.0		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consec	quence of):									
	ocuted nd transi	Examiner	that initiated events	С.	iabete										
Š,	e exe		resulting in death) Last		ras a consec										
9/8 8/90	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai		dH	yperte	ension								-	
S X	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outco	ome of prean	ancy						-			
XOR	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1□Live bir	th 2 Feta	al death 3	Ectopic pre					23	d. Date of deliver Month	•	Year
o.	at the de by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov											
J	res that igned b be deta	by Pł	Part II. Other significant condition	s contributing to dea	ith but not re	sulting in the u	inderlying ca	use give	n in Part I		23e. Did to	obacco use	contribute to	the cause of	death?
Vital Records,	quires n sign										1 🗆 Y	/es 2□	No 3∏XPro	bably 4 🗌	Unknown
ပ္ပ	s been si s should t	Completed									24a. Was		24b. Were aut	opsy findings	available
ž	The law cate has l	mo										med?	prior to condeath? 1 ☐ Yes	ompletion of a 2 ∏ No	cause of
<u>a</u>		0	25. Was case referred to medical					•	26. Place	of Death	(Check only o	ne)	1 🗆 103	× X 140	
	yslcl iis ce direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Hn	patient 2] ER/Outpatie	nt 3 DO	A Othe	er: 4 □ Nu	rsing Ho	me 5 Resid	dence 6	☐Other (Spec	ity)	
n of	ding Ph h. After thi funeral		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o	f 28	Bc. Injury Work	at ?		28d. Describe h	now injury	occurred		
<u> </u>	Vttsndli death. ctor: A y the fu	atic	2 Accident investiga				М	1 🗆 🗅	/es 2 🗌						
Division	i or Attan after deati Director:	Certification;	3 Suicide 6 Could no 4 Homicide determin	289. Place C	of Injury - At h g, etc. (Speci	nome, farm, st ify)	reet, factory,	office			28f. Location (S City or Tow		Number or Rui	al Route Num	nber,
	urs al pral D		VV												
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier **ACertifying (Check only 2 Medical E	Physician: To the best common and manners	is of examina	owiedge, deat ation and/or in	n occurred a vestigation,	it the tim	e, date an sinion, dea	id place, th occurr	and due to the o ed at the time, o	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s	s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manne			29c.	License	number			29d. Date	signed (Month	Day, Year)	
	H 3 H Ö		> Doop a	AURSE	a.	M)	D005	2075			5/	2/05		
. 1	XI		30. Name and address of person w	ho completed cause	of death (Ite	m 23a) (Tvne				<u>-</u>		-/-	/		
H	17		Deep Kukreti					ve #	223	, Laı	ırel, MI	D 20	707		
	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Sign		realis		-						
	Registr	ar	HU1 0 +	2000		~ /									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) MAY **Physician** 02 2005 1:35 A M Cecelia Marie Kurtz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 14 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 1923 **Funeral** Days Hours 1 ☐ M 200 F 82 Jan. Pennsylvania 165-16-2959 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, Ite Mcdical Examiner riust be motified at 1 Yes 2 No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 United States 6210 Marietta Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: δ Specify: filed within 72 hours: Hygiene. 3 Widowed 4 Divorced White and Mental Hygiene. Is marked other than "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 Yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matilda Unknown Murcavich George 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Heelth and Important: If item 27 Is n any injury or other traun 2006. 6210 Marietta Avenue Baltimore, Maryland 21214 Mr. Michael J. Kurtz, Jr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 5/06/2005 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician inly muediate Trobable /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause fine lineshing Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner cate has been signed by the attending physician and , page 2 should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 □Ectopic pregnancy Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. D te of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death.

after death Director:

filled in by within 24 hours at To the Funerel D completely filled i Hospital the

4 Thomicide

(Check only one)

MATILDA

31. Date filed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier Marilda

2005

#

29c. License number MD 156520

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

CHARLES ST NORTH 32 Registrar's Signature

Baltruine, M.D. 21204

DHMH 17 Rev 1/2001

GEORGE KULWEIN 05-03038 RKD

)			Ficase					d Mostal III	_	DIC.				
			For State	State of Ma	-	epartment of Certificate o		d Mental Hy	21	100	1 1-4	0.1		
			Registrar 1. Decedent's Name (First, Middle, Last	•)		erincale o	Dealli	2. Date of De	Reg. No. 🛴 🕽	JUJ	3. Time of D	Death		
	Physici	an	George		wein			Month	Day	Year				
1	/Medic		4a. Facility Name (If not institution, give		WCIII	Ab Ciby Tour	or Location of F	MAY		005	7:26A.			
4	Examin	IC 1	North Bound I 95 @		ker 565	BALTIN	i, or Location of D	Deatti	4c. County of Death					
			5. Social Security Number 6. Se		e (In yrs. last birtho			Hrs. 8. Date of Bir	th	9. Birtho	lace (State or i	Foreian		
	Funeral Director			Ж и 2□ F	59 Yr	Months Day		Min. B. Date of Bin (Month Date 20	, 1945	Aust	lace (State or i itry) ria			
			Usual Residence of Decedent											
	how		10a. State 10b. County		10c. City, Town of					1	0d. Inside City			
	Sa-1s	cto	New Jersey Ocea	n	Little	Egg Harbo		nip			1 XYes 2			
	1 th	Dire	10e. Street and Number			10f. Zip Code	∍ 087		10g. Citizen of V		-			
	filed within 72 hours after death with the Maryland Hyglene. wher then "neturel", or Items 23e or 28e-f show with the Medical Erati, for must be rediffed at	by Funeral Director	12 Chape1 Lane	10.111	1:110			2/2 7 1/2						
	er de	nue	11. Marital Status 1 □ Nøver Married 2 Married	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 N	ever in U.S.	If Yes, specify C	it Hispanic Origin uban, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	Blac	e - Am <i>e</i> ric ck, White,				
36	rs aft	oy F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	*0	1 ☐ Yes 🏖 N	No Specify:		Specify	. Wh	ite			
Ö	2 hou	ed	15. Decedent's Ed	ucation	16a. D	ecedent's Usual Oc	cupation		16b. Kind of B	usiness/Inc	dustry			
712	7 nin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1:4or 5	<u>+)</u>	ecedent's Usual Oct Give kind of work do fe. DO NOT use ret	ne during most oi ired)	t working						
21	filed withir Hygiene. Ither then	Completed		1	L	imousine	Driver		Resort	s In	ternati	ional		
pu		Be (17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Suman	10)				
/lai		70	George Kulwein					Michaelo						
Maryland 21215-0036	2 sho and is mu	·	19a. Informant's Name/Relationship (7					or Rural Route Numb				3 7		
	rt 2		Joan Jamieson Kul	lwein, Wif				tle Egg H						
ore	ges 1 au t of Hea If item or othe		20a. Method of Disposition 1 Burial 2 Tremation 3	Removal from State	cemetery.	isposition (Name of crematory or other p	olace)	Date 05 /07 /05	20c. Location -					
Ë	nit. Pag artment ortent: injury e		4 □ Donation 5 □ Other (Specify)	ocean co	unty Memoria		Wood Fune	loms River					
Baltimore,	permit. Pages Department of h Importent: If ite any injury or of		21. Signature of the last of the local	M01	113	22. Name and Ad 134 East	dress of Facility Main Str	eet, Tuck	erton, l	ij 08	087			
			23a. Part1. Enter the disease, or comp			enter the mode of o	tying, such as ca	rdiac or respiratory a	rrest,		Approximate			
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	ne.		•				Interval Betwee Onset and De	een eath		
	Physician /Medical		disease or condition resulting in death)	a. Head	a consequence of	ck injur	165			_				
	Examiner			200 10 (01 00)	a consequence or,	. •								
		ē	Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury	b. Due to (or as :	a consequence of)	C. C.		-						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C										
ó	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequence of)	:								
3760,	The law requires that the death certificate be executed tate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	icai		d										
89	death certificate b attending physic I for use as the b	Med	IF FEMALE:											
Вох	ath ce itendi	an/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregna				te of delive inth		ear		
O.	e dea the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 ☐ Other (specify,)				,			
Р.	that the de led by the a detached f	P _y	Part II. Other significant conditions co	entributing to death be	ut not resulting in t	he underlying cause	given in Part I	23e. Did t	obacco use cont	ribute to th	ne cause of dea	ath?		
S,	ires tha signed d be de	l by	atti. ottor significant osticitions of	ontributing to death be	at not resulting in t	is underlying cause	givoirarr airt.	1 🗆			ably 4 ⊟Un			
Records,	w requir been si should	Completed						044 145	-					
3ec	e law has t	mpi						— 24a. Was	osy	prior to cor death?	psy findings av mpletion of cau	use of		
E								12 Yes	2 No		2 No			
Vital		Be	25. Was case referred to medical examiner?	Hospital:			0.:	Death (Check only of			CCEME			
of	Phys this ral di	- 70	1 XYes 2 No 27. Manner of Death	1 Inpatie 28a. Date of Injur	nt 2 ER/Outp rv 28b. Tin	atient 30 DOA	4 ∐ Nursi	ing Home 5 Resi	dence 6 🔼 Oth how injury occur		NOCENE ~			
on	tending Ph Jeath. tor: After th the funeral	tion	1 □ Natural 5 □ Pending 2 🛣 Accident investigation	(Month, Day	y Year) Inju	ıry V	Vork? √Yes 2 □ No	, driver	of limos	1.0	4	Lsiòn		
Division	t or Attending after death. Director: After In by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. lace of Inju	ury - At home, fam	n, street, factory, offi	сө	28f. Location (Street and Numb		I Route Numb	er,		
Ö	E City	Certification:	4 Homicide determined	building, etc	c. (Specity) hichwa	u		NevThbou	1 T95.a	+ mile	marker &	565,		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by				of my knowledge,	death occurred at the		place, and due to the	cause(s) and ma	nner as st	ated.			
	the H in 24 the Fi	Medical	one)	and manner sta	ated.			occurred at the time,						
	With To T	Z	29b. Signature and title of certifier	1			ense number		29d. Date signe		Day, Year)			
•	. /~	/	Jashay 1.	neens	erg All	/	OCME	1	MAY $2, 2$.005				
i	7-11		30. Name and address of person who	1	eath (from 23a) (T									
1			1000/(0-	nberg	M.D.	111 Pen	n Stree	t Baltimo	re, Mar	/land	21201			
	Sta Regist	ate	31. Date filed (Month, Day, Year)	0 4 2085	ar's signature	So Page	,445							
	negisi	rai	n(A)	4										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registragmend item #7 per fh g843 5/Qqqqqqqq of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:30 P APRII. 30 2005 LILLIAN KLITZNER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE TIMONIUM STELLA MARIS HOSPICE Hours Min. 02/172/1919 Birthplace (State or Foreign Country)
 MD If Under 1 Year 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 🗙 F MD 86 81 216-18-3844 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State or 28a-f show 77 is marked other than "naturel", or items 23a or 28a-f shov traumatic event. The Medical Examinar must be nutiliad at 1 ☐ Yes 2 🜠 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21208 8911 REISTERSTOWN ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: Completed by 3 N Widowed 4 □ Divorced PAIL 30th, 2005 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GROCERY OWNER/OPERATOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H em 27 is markad oth BERKOWITZ MINNIE GOLDBERG SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Importent: it item 27 is any injury or other trat once. BALTIMORE, MD 21208 4 MONTAIGNE COURT MARTIN KLITZNER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/03/2005 ROSEDALE, MD **KOVNA** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Tolet 8900_REISTERSTOWN_ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMORRHAGIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Examiner burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical the ası IF FEMALE of Vital Records, P.O. Box esn. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOTICE 1 ☐ Yes 2 X No ု this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Hospitel or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Text Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Imagical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

KLITZNER

State Registrar

DR. TARIB MOHMOCD 31. Date filed (Month, Day, Year) MAY 0 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

2300 DULANEY 32. Registrar's Signature

VALLEY

29c. License number

2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Α. 11:22 A M ALTA KLITENIC MAY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 19, 1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. 212-52-1600 74 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 9206 JAMES HOWARD LANE 21208 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: WHITE Specify: Completed by 3 X Widowed 4 ☐ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **GOLDMAN** WEINSTEIN ALBERT BELLE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 BEECHAM COURT - OWINGS MILLS, MD 21117 item 27 MARC A. KLITENIC / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Importent: If it eny injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN, MD HEBREW YOUNG MEN CEM. 05/03/2005 ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** -ardiac disease or condition resulting in death) arrest /Medical Due to (or as a consequence of): **Examiner** [robable erforated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi) Examiner lor Attending Physiclen: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Be Completed by Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Minknown 1 ☐ Yes 2 ☐ No cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Chack only one) ro the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Md # D15552 M.D 5/2/05 Q. 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ste. #340 Owings Mills md. 21117 Crossrands Pai intz 23 24 . D 32. Refistrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 3:30 p Michael Leroy Kehr April 27, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Manchester Carroll 3399 Lineboro Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex) 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Yrs. Director 54 214-56-0753 October 26, 1950 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count or 28e-1 show the Medical Examinant set by nutilied at 1 ☐ Yes 2 X No Director Manchester MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. items 23e 21102 3399 Lineboro Road Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nnt: If item 27 ie marked other then "naturel", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 V No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Electrical College (1-4or 5+) Elementary/Secondary (0-12) Electrician treumetic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Betty Jean Posey 2 Leroy Daniel Kehr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3399 Lineboro Road Manchester, MD 21102 other Spouse Ms. Donna M. Kehr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ŏ 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or 04/30/2005 Marriottsville, Maryland 14 □ Donation 5 □ Other (Specify) Crest Lawn Memorial Gardens Shatu of Funaral Service Lice 22. Name and Address of Facility Slack Funeral Home, P.A mille 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consuguence of Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 5 Other (specify) P.O. E ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by IMMUNOSEN PRESENON 1 Yes 2 No 3 Probably 4 Unknown TRANSPLAN 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 1 Yes 2 - NO Division of Vital To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manual D 1 Natural T Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide hours after within 24 hours.
*he Funerel D 29a. Certifie l 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) and title of certifie 29b. Signat 3 and address of person who completed cause of death (Item 23a) (Type, Print) -lavio hruter mi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Maryla		partme e <i>rtifica</i>			Mental H	ygien Reg. Ne	2001	5 15	01 0	
			Decedent's Name (First, Middle, Last)			37111100	10 01	Douth	2. Date of D		one O U	3. Time	of Death	
	Physici		Josephine	Valentina	Lambe	rt			Month May	O.		5 8:15	PM	
	/Medio Examin		4a. Facility Name (If not institution, give s		Lambe		y, Town, o	r Location of Dea		-	c. County of De			
			North Arundel	Hospital		16	rela	Burr	ile		Anne A	frunde	r).	
	Funeral		Social Security Number 6. Sex	7. Age (In yr.		y) If Und Months	er 1 Year Days	If Under 24 Hr Hours Mir		irth ay, Year	9. B	irthplace (State Country)	-	
	Director		195-18-3029	80	Yrs.				Feb. 1	18,19	925 P	ennsylv	ania_	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or	Location						10d. Inside	City Limits	
	Manyl f sho	ō	Manual and American							1 ☐ Yes 2 🛣 No				
	28a	Director	Maryland Anne Ar	ипает	se	vern	ip Code			10a. C	itizen of What	Country?		
	death with the Maryland ms 23a or 28a-f show froust be notified at		1600 George Avenu	e			21	144			United	States	3	
	death ms 2	Funeral		12. Was Decedent Ever in	U.S. 13	3. Was Dec			(Specify Yes or Norto Rican, etc.)	10-		nerican Indian,		
ψ	after or fte	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes		an, mexican, Pue Specify:	erro Hican, etc.)		Black, WI	nite, etc.		
33	ural',	d b	3 □XVidowed 4 □ Divorced	Year or Dates:							Specify:	White		
ephine 21215-003	"natu	Completed by	15. Decedent's Educ (Specify only highest grade	cation e completed)	(Gi	cedent's Us	vork done	during most of w	orking	16b. i	Kind of Busines	s/Industry		
25	withir ane. than	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		. DO NOT		ovider		9,	elf-Emp	1 oved		
d2	filed Hygid other ant, t		17. Father's Name (First, Middle, Last)) Da	y car	e rre	r	ame (First, Middl			Toyeu		
t, Josephine Maryland 21215-0036	td be ental ked c	To Be	Joseph Frank	Golobic				Mary		orie.				
ary.	shou ind M mar umat		19a. Informant's Name/Relationship (Ty)	рө, Print)	19b. Ma	iling Addre	ss (Street	and Number or I	Rural Route Num	ber, City	or Town, State	, Zip Code)		
_	alth a		Sandra Ann Bast/d	aughter	1600	Geor	ge Av	venue S	evern, N	lary]	land 21	144		
S e	es 1 a of He fiterr roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		Place of Dis	position (Na rematory or	ame of other plac	ce)	Date	20c. L	ocation - City	or Town, State		
Z <u>E</u>	Pag ment ant: I		'4 □Donation 5 □ Other (Specify)	We				atory 5/			denton,	•	ınd	
amber Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities in at the notified at ODGe.		21. Sign up e of Funeral Service License	99		22. Name a	and Addre	ss of Facility Funeral	Home &	cre	matory,	P.A.		
	70 F 4 0				<u>0957 1</u>	411 A	nnap	olis Roa	id Odeni	ton,	Maryla	nd 2111		
			23a. Part1. Inter the disease, or compli shock, or heart failure. List only or				oae or ayır	ng, such as cardi	ac or respiratory	arrest,		Approxim Interval B Onset an	Setween	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	3	CANC	E12				_				
	Examiner			Due to (or as a conse	equence of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):							-	-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	equence of):									
8760,	ite be nysicia he bu	dical		d								-		
9	artifice ing ph e as th		IF FEMALE:											
Вох	ath ce ttend	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1□Live birth 2□Fe	tal death	3 Ectopic		/			23d. Date of d Month	elivery Dav	Year	
	ne de the a	Physiclan/Me	1 ☐ Yes 2 😾 No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	5 ☐ Other (s	specify)			ŀ		,		
P.0	requires that the death certific een signed by the attending p nould be detached for use as	Ph	Part II. Other significant conditions con	ntributing to death but not re	sulting in the	underlyina	cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause o	f death?	
ds,	w requires that been signed to should be deta	d by							15	Yes 2	2 □ No 3 □	Probably 4 [_Unknown	
Š	- O 75	lete							24a. Wa	san	24h Were	autonsy finding	s available	
Be	e la has je 2	Completed							auto	opsy formed?	death'	autopsy finding completion of	cause of	
ta	iclan: Th certificate rector, pag	ပိ	25. Was case referred to medical					26 Place of D	1 ☐ Yes eath (Check only		0 1 1 Y	s 20No		
<u> </u>	Physiclan: this certificanal director,	0 8	avaminar?	lospital:	☐ ER/Outpat	ient 3 🗆 🗈	Oth	05	Home 5 ☐ Res		6 □Other (St	ecify)		
0	g Phys ter this neral dii	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)		of	28c. Injur Wor	y at	28d. Describe					
ië	Attending r death. sctor: After y the fune	atlo	1 Natural 5 Pending investigation	(monus, day roar)		М		Yes 2□No	aller alle voer for					
Division of Vital Records,	r Atte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm,	street, facto	ry, office		28f. Location City or To	(Street a	nd Number or i	Rural Route Nu	imber,	
٥	oital ours af			1										
	Hosp 24 hol Fune fely fi	Medical	(Check only 2 Medical Examin	sician: To the best of my kinner: On the basis of examin	nowledge, de nation and/or	atri occurre investigatio	on, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	a causa(s), date an	s) and manner id place, and d	as stated. ue to the cause)(s)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Mec	29b. Signature and title of certifier	and manner stated.		2:	9c. Licens	e number		29d. Da	ate signed (Mo	nth, Day, Year		
	F ₹ F 8		Dorlie 12a	cohun	MA	1			23		-		_	
	1		30. Name and address of person who co	omoleted cause of death (It.	am 23a) (Tun	e Print	~3 0 (3 3 7		140	1010	,		
/	0		Zeilk Deise	11500 Suthe	> land	HI	4	NAG S	73	PR/N	14,04	b 200	104	
	Sta	ate		32. Redistrar's Sig	nature	1	V. 1			, , ,				
	Registr	rar	MAY 0.4	2005 400000	D.	L4004	4							

Robert John Lehr 05-02966 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene on or

1501.6					
		1779	(3)	1	pro
	1	. 1	11	1.2	m

		•	1 - State Registrer	,	Cer	tificate of	Death		Reg. No.	15 15046			
	Physici	an	1. Decedent's Name (First, Middle, Last)		_			2. Date of De. Month		3. Time of Death			
	/Medic	al	Robert John Leh			# 6' T	1	April	29 200				
	Examin	er	4a. Facility Name (If not institution, give s 10900 Block of Gas	· ·		New Ma	r Location of Deat っとっさ	n	4c. County of Freder				
	Funeral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Year	If Under 24 Hrs			D. Birthplace (State or Foreign Country)			
i.	Director		225-55-4395	M 2□F 17	Yrs.	Months Days	Hours Min.	Nov. 9	, 1987	Virginia			
	pu 🗼		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	antion				10d. Inside City Limits			
	shov shov	5								1 ☐ Yes 2 ★No			
	28e-f	ect	Maryland Freder 10e. Street and Number	ick Un	ion B	10f. Zip Code			10g. Citizen of Wh				
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show the M. cifel Examinar must be notified at	Funerai Director	9005 Clemsonvil	le Road		2179)1		United				
	death	nera		12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of H	lispanic Origin? (S	Specify Yes or No	- 14. Race -	American Indian,			
9	after or Ite	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 Tes, specily Cuba 1 □ Yes 2 ☑ No		to Alcan, etc.)	Specify:	White, etc.			
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:									
7	"net	iete	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busin	ness/Industry			
21215-0036	withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Student	-/		Linganor	e High School			
ğ	be filed Ital Hygi Id other event,	Be C	17. Father's Name (First, Middle, Last)						Maiden Sumame)				
ylaı	should b and Ments s marked umetic e	To	John R. Lehr				Bel	inda Do	oyle				
Baltimore, Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "neturet", or Items 23e or 28e-1 show or other treumetic event, the Wedical Examble in utilitied at		19a. Informant's Name/Relationship (Ty						er, City or Town, St. n Bridge,				
e,	1 and Health em 27 ther 1		Mrs. Belinda Burr 20a. Method of Disposition			sition (Name of	tite Roa	Date					
Jou	permit. Pages 1 and 2 Department of Health a Importent: If item 27 It eny Injury or other tree		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Linganore Cemetery May 3, 2005 Unionville, MD										
alti.	mit. F partme sorter injur		21. Signature of Funeral Service License						& Crema				
m	Depar Impo eny ir		Janu B	cens	- 1	212 W. 01	d Libert	v Road	Winfield	, MD 21784			
П			23a. P - 11. Enter the disease, or compli	ications that caused the death. ne cause on each line.	Do not ent	er the mode of dyin	ig, such as cardia	c or respiratory a	rest,	Approximate Interval Between			
	Pnysician.	1	In mediate Cause (Final 154 ase or condition resulting in death)	MUNTUE	THI) Rus				Onset and Death			
In	/Medical Examiner		resulting in deathy	Due to (or as a conseque	ence of):								
		er	Sequentially list conditions, by the conditions, cause. Enter Underlying Cause (Disease or injury)	Due to (or as a cons∋que	ance off:	3							
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
Ö,	e exection and an arrial-tr		resulting in death) Last	Due to (or as a consequence of):									
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical		d									
9 xo	ding p		IF FEMALE:	3c. If yes, outcome of pregnan	ĊV		-		22d Date	of delivery			
Bo	the death by the attent ached for u	Physician	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)	′		23d. Date of Month				
o.	that the de led by the a detached t	hysi	9 Unknown	9□ Unknown									
s, D	The law requires that ite has been signed b age 2 should be deta	by P	Part II. Other significant conditions cor	ntributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribi	ute to the cause of death?			
ord	equir sen si ould			· · · · · · · · · · · · · · · · · · ·				10	res 2 No 3	☐ Probably 4 ☐ Unknown			
Records,	e taw i has be	Completed						24a. Was autor	osy prio	re autopsy findings available			
								Yes	rmed? dea 2□No f∈	Yes 2 No			
Vital		o Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	fospital: 1 Inpatient 2 E	D/Outesties	t all DOA Oth		ath (Check only o		(One) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
of		n: To	27. Manner of Death		28b. Time of	28c. Injur	y at		now injury occurred	(Specify) at scene			
Division	Attending F r death. ector: After by the funera	Certification:	1 Natural 5 Pending 2 Accident investigation	4-29-05	Il: ID	AM 1	Yes 2 No			upper must asi			
ĭ	or Atter de after de Directo	rtific	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route Number, HD			
	Hospitel or Atten 14 hours after deatl Funerel Director: tely filled in by the		20n Cortilios 4 Contibular Bb	Pop Du	-		datad!		-	IKE HOW H DOKET			
	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	edicai	29a. Certifier 1 Certifying Physics (Check only one) Medical Examination	sician: To the best of my know ner: On the basis of examination and manner stated.	n and/or inv	occurred at the tirt vestigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)			
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	N		29c. Licens	e number		29d. Date signed (i	Month, Day, Year)			

O.C.M.E.

April 30, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

Registrar

			State Registrar	State of Marylan		artment of Hotelificate of L			jiene 0 0	5	5047
	Physici	an	1. Decedent's Name (First, Middle, Last) Willard R. Leonar	·d				2. Date of Dea Month April	30 2005		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death	<u> </u>	4c. County of		5,001.
			515 Carlsbad Cour				verview			Baltir	
	Funeral Director		5. Social Security Number 6. Sex 1₺1	7. Age (In yrs. 8	last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jun 2	Year) 1922	i. Birthplac Country, VIY	e (State or Foreign Sinia
	g		Usual Residence of Decedent 10a. State 10b. County	10g Cit	y, Town or Lo	antion				104	Inside City Limits
	daryia f show	٥	MD Baltimo		y, rowir or Lo	Riverv	ri ew			104.	1 ☐ Yes 2 No
	r 28a-	irect	10e. Street and Number	,10		10f. Zip Code	TCW		l0g. Citizen of Wh	at Country	?
	th with	aD	515 Carlsbad Cour	t			21227		United	l Stai	tes
036	urs after dea al', or items Excadine can	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1. Yes 2 No 2-2 If Yes, Give Year or Dates: 12-23	24-43	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Black, Specify:	White, etc	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene do ther than "natural", or items 23a or 28a-f show ovent, I're Madical Examinating and event, I're Madical Examination of the continuation	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ition	16a. Deced (Give life. I	dent's Usual Occupa kind of work done d DO NOT use retired) Pipe Fitt	uring most of wor	king	16b. Kind of Busin Baltimor Electric	e Gas	•
/land 2	m - 0 3	To Be C	17. Father's Name (First, Middle, Last) Richard T. Leonar	·d				ne (First, Middle, Clizabeth	Maiden Sumame) 1		
Man	12 sho n and ls ma rauma		19a. Informant's Name/Relationship (Type	·_ ·	1	ng Address (Street a					ode)
ē,	tand Health tem 27 other tr		20a. Method of Disposition) .	Place of Dispo	Carlsbad sition (Name of		Civerviev Date	20c. Location - Ci		, State
Ē	Pages nent of nnt: If it	1	Burial 2 © Cremation 3 Re '4 Donation 5 Other (Specify)	moval from State	-	natory or other place rematory,		-3-2005	Baltimor	e, MI)
Balt	perrist. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once.		21. Sollatur Tuneral Service Licens	4000 r	13	Name and Addres 28 Sulphu	r Spring	Road, A	Arbutus,		
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	6	th. Do not ent	er the mode of dying	g, such as cardiad	or respiratory arr	est,	In	oproximate terval Between nset and Death
8760,	The law requires that the death certificate be executed and the has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consec	Juenos of).	ia L	ing			2	va sig
.O. Box 6	that the death certific led by the attending p detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of c 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		y Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying cause give	on in Part I.		bacco use contrib es 2 □ No 3	ute to the d	
I Records,		Completed						24a. Was a autop: perfor 1 Yes	med? dea	ere autopsy or to compl ath? Yes 2[r findings available letion of cause of
Viital	Phyaiclan: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	spital:	150/0	Othe	are:	th (Check only or		10. 11	
Division of	Attending Physic death. ector: Atter this by the funeral di	 	1 Yes 2 No 27. Manner of Death 2 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	4 Nuising n		ence 6 Other ow injury occurred		
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely tilled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Number n, State)	or Rural R	oute Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely tilled in it	edicai (cian: To the best of my known: On the basis of examination and manner stated.							
	To the H within 24 To the Fi complete	×	29b. Signature and title of certifier			29c. License			29d. Date signed (
				ye		11)2	5044		11/18		
	5		30. Name and address of person who con	npiered cause of death (Ite)	m 23a) (Type,	7 totas	om as of	Ferro	hold b	all	M
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0	4 2005 Registrate Sign	ature	Aprila		+ + /		2	(2r)

LEUNARD WITHING R.

		State of Maryland / Dep	ertificate of			giene Reg. No.2 11 11	E IEOLO
Physician	ı	1. Decedent's Name (First, Middle, Last) LEWIS DENNIS LEAPLEY			2. Date of De Month APRIL	ath	3. Time of Death 3 : 40 P M
/Medical Examiner		4a. Facility Name (If not institution, give street and number) 4026 27th Ave	4b. City, Town, o	r Location of Death	AFRIL	4c. County of	
Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday 17. Age (In yrs. last birthday 18. Security Number 18. Securi		If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da July 1	th g	3. Birthplace (State or Foreign Country) Vashington DC
D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		1	oury r		10d. Inside City Limits 1 ☐ Yes 2 ▼ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show misportant: If item 27 is marked other than "neturel", or Items 23a or 28a-f show piny or other traumetic event. The Madical Extra cliner challed and process.	n Direct	Maryland Prince George's Temple 1 10e. Street and Number 4026 27th Ave	10f. Zip Code	0748		10g. Citizen of Wh United S	at Country?
ad within 72 hours after death v gleine. ar than "neturel", or Items 23a. the Medical Exic liner outs.	y runera	1 Never Married 2 Married 1 Two S 2 No WWII	. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No Rican, etc.)		American Indian, White, etc.
ed within 72 hours a ygiene. Nar then "neturel", o t. the Medical Externation	d paraid	15. Decedent's Education (Specify only highest grade completed)	edent's Usual Occup	during most of work	ing	16b. Kind of Busin	White ness/Industry
d other the event. The A		Elementary/Secondary (0-12) College (1-4or 5+) Mil 1 17. Father's Name (First, Middle, Last)	kman			Food In	
Is marked raumetic e	0			and Number or Rura		er, City or Town, St	Tate, Zip Code) 30339 10, Atlanta, Ga
ages raind of Health		20a Method of Disposition 20b. Place of Disp	oosition (Name of ematory or other pla	! .	Date	20c. Location - Ci	
Departme Importan any injur		21. Signature of Funeral Service Lange	22. Name and Addre	1	Funera	1 Home,Ir	nc 6633 Old
ysician Medical kaminer		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY I Due to (or as a consequence of): CONGESTIVE HEART	DISEASE	ng, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between Onset and Death
physician and s the burial-transit	ĭ	Cause inter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of): d.					
the attending hed for use as	Physician/med		☐Ectopic pregnanc	у		23d. Date Month	
e e e e	2	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	ven in Part I.			ute to the cause of death? Probably 4 Unknown
has le 2	Completed				24a. Was auto perfo 1 Tyes	osy prio	ere autopsy findings available or to completion of cause of ath? Yes 2x No
this cert	10 Be	25. Was case referred to medical examiner? 1 Yes 2 A No Hospital: 1 Inpatient 2 EP/Outpatie 27. Magner of Death 28a. Date of Injury 28b. Time	of 28c. Inju	26. Place of Death ner: 4 Nursing Ho ry at	me 5XXR]esi	dence 6 Other	
after death. Director: After I in by the funer	Certification:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	M 1 🗆	rk? Yes 2 No	28f. Location (City or To		or Rural Route Number,
24 hour	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dead of the best of my knowledge, dead on the basis of examination and/or and manner stated.	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
within To the compl	Me	29b. Signature and two of certifier Hypice IMD	29c. Licens			29d. Date signed (
XX		30. Name and orders of person who completed cause of death (Item 23a) (Type PATRICK C. JOYCE, M.D., VAMC, 50 IRV 31. Date (iled (Month, Day, Year)) 22. Registrar's Signature		ET NW, WAS	HINGTON	I,D.C. 20	422/688
State Registra		31. Date filed (Month, Day, Year) MAY 0 4 2005	vile)		2		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 8. Time of Death Dav Month Year **Physician** Sue Worthington Layman 29, 2005 2:30 PM <u>April</u> /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6917 Garrett Road Derwood Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 214-28-7592 Director Washington, January 12, 1932 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits of Health and Mental Hygiene. Item 27 ia marked other then "natural", or items 23a or 28a-1 shov other traumatic event, the Medical Examinat must be notified at 28a-f show 1 ☐ Yes 2X No Director Maryland Montgomery Derwood the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With United States 6917 Garrett Road Completed by Funeral 20855 Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. ☐Yes 2 X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 X Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Arthur James Sherwin Margaret Ann Cline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Layman Mills/ Daughter 10806 Utica Mills Circle Thurmont, Maryland 20788 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. ^¹ 4 □ Donation 5 □ Other (Specify) May 3, 2005 Bethesda, Maryland Crematorium Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Pumphrey Funeral Home/ **⊀**М00335 23a. Part1. Enter the disease, or compercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **tancreatic Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 2 1100 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 2X No 1 Yes Division of Vital Hospital or Atlending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To ŧ this (After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death investigation after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) p 4 Homicide A 24 house the Funeral Dig No filled in Medical 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signati 29d. Date signed (Month, Day, Year) e and title 2 May 2, 2005 30. Name and address of person 100 completed cause of death (Item 23a) (Type 18111 22822 7025 by Kurumi Wa Prince 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			- State Registrar AMEND III	State of Ma M #7.17818						g. No.	
	Oisi		Decedent's Name (First, Middle, La						2. Date of Death Month	1 1 1 1	3. Time of Death
	Physici /Medic	al	Mary L. Lewis						April 3	30, 2005	12:55 P M
	Examin	er	4a. Facility Name (If not institution, giv					r Location of Death		4c. County of De	
	Euporal		Shady Grove Adv 5. Social Security Number 6. S		oital (In yrs. last bii	rthday) If Un	ockvil der1 Year	If Under 24 Hrs.	8. Date of Birth	Montgom 9.8	Sirthplace (State or Foreign
	Funeral Director			1□M 2\ F 87	73	Yrs. Month	ns Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 15,	1918 Ma	Country) ssachusetts
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location					10d. Inside City Limits
	Maryla f sho	ō	Maryland Montgo	nerv		tgomery	Vi11	age			1 ∑ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number	J			Zip Code		10	g. Citizen of What	Country?
	th with	al D	19310 Club House	Road			20866			United S	States
	tems er dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was De If Yes, s	cedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, Ite Modical Exemples must be multified at	5	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:) 	1 ☐ Yes	s 2 ∑ No	Specify:		Specify: W	Thite
15-("netu	lete	15. Decedent's E (Specify only highest gr		16a	. Decedent's U (Give kind of life. DO NO	work done	during most of work	king 1	6b. Kind of Busines	ss/Industry
12	e filed within al Hygiene. I other then vent, Ira Mo	Completed	Elementary/Secondary (0·12)	College (1-4or 5-	-)	Actres		•		Enter	tainment
ld 2	other	Be C	17. Father's Name (First, Middle, Last)	1			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
ylar	should be and Mental marked o	To B	(Unknown) Lopez	JOSEPH LO	PES			(Unkne	ORINA FER	REIRA LO	PES
Maryland	2 sho and Is me		19a. Informant's Name/Relationship		1					City or Town, State	
	Health Health tem 27 other tre	1	David Asaki/Atto	orney		Of Disposition (, ROCKVIL Oc. Location - City	1e, MD 20850
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or ot		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	fy)	cemete	ontgome ontgome natoriu	erother place ery m, Inc	c. May 3			Maryland
Ball	Departiment Departiment Important any in 2005s.		21. Signature of Funeral Service Liqu	2016	01420	Robert 300 W	and Addre : A. Pu est Moi	ss of Facility Imphrey Fun ntgomery Av	eral Home/I enue, Rock	Rockville, ville, Mary	Inc. yland 20850–2805
ij			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do	not enter the n	node of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acute	Renal I	Failure					Onset and Death Days
	/Medical Examiner		Todaking in doubly	Due to (or as a							Marcalan
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Type I	L Diabe	etes					Years
	icate be executed physicien and s the burial-transit	Examiner	that initiated events				cer w	ith Osteo	myelitis		Days
30,	rificate be executed ng physicien and as the burial-transit		resulting in death) Last	Due to (or as a	consequence	of):					
68760,	physic physic	Medical		d							
Box 6	E B		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of d	deliverv
	att	Physician/	in the past 12 months?	1 Live birth 2 4 Pregnant at t		h 3 ∐Ectopio 5 □ Other	c pregnancy (specify)	<i>'</i>		Month	Day Year
P.0	at the de by the stached	hys	9 Unknown	9□ Unknown							
	res that signed b	by	Part II. Other significant conditions	contributing to death bu	t not resulting i	in the underlyin	g cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
örc	w require been si should l	eted									
Records,	The law ate has page 2 s	Completed		·					24a. Was an autopsy perform	prior t ed? death	
Vital		Ф	25. Was case referred to medical					26. Place of Deat	1 Yes 2. th (Check only one	X No 1 □ Y	es 2 No
fVi	d is	To B	examiner? 1 ☐ Yes 2 ∑ No	Hospital: 1 X Inpatier	t 2 ER/O	utpatient 3	DOA Oth			nce 6 Other (Sp	pecify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injur Wor	y at k?	28d. Describe how		
isio	Attendii death. ctor: Ay y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be			M		Yes 2 □ No	20f Leasting /Ctr	ant and Alumbas as	Core Courte Month or
Division	of or Attendates after death	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc.	(Specify)	arm, street, iac	тогу, оптсе		City or Town,	State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier 1 X Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best o miner: On the basis of and manner stat	examination ar	e, death occurr nd/or investigat	ed at the tir ion, in my o	me, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	man - N	1		29c. Licens	_		d. Date signed (Mo	, ,
	ON	1	s. Humba	June , I			v ·	31391		May o	1,2005
	60		30. Name and address of person who				o D	1 #100 5	- oler-417	M1	1 20050
	Sta	ate	Suhair Abulfarag 31. Date filed (Month, Day, Year)	20 8	4- 06		1.21		ockville,	Maryland	1 20850
ŧ	Regist		MAY	7 0 4 20 5	Glasus	See 1	Good				

			For State Registrar	State of M	aryland / Depa	artment of H		•	giene Reg. No. 0 0 5	15051
	Physici	an	1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month	ath Day Year	3. Time of Death
	/Media	al	Teny Lach 4a. Facility Name (If not institution, gir	ve street and number)		4b. City Town or	r Location of Death	April	29 , 2005 4c. County of Death	5:12 AM M
	Examir	ier	Johns Hopkins	,			Baltimore	<u>.</u>		
	Funeral				ge (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	h 9. Birth	nplace (State or Foreign
	Director		219-16-2132	1□M 2ØF	85 Yrs.	Montals Buys	TTOGES IVIII.	07/30/		
	Mo H		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary 1-f sh	ţō	MD Baltimo	ore City	Baltimore	9				1 ØYes 2 □ No
	th the	lrec	10e. Street and Number		-1	10f. Zip Code			10g. Citizen of What Co	untry?
	ath wi	rai	1033 Rockhill Ave			21229			United Stat	
920	ges 1 and 2 should be filed within 72 hours after death with the Marylend tof Health and Mental Hygiene. If Itam 27 is marked other than "natural", or items 23s or 28s-f show or other traumetic svent, it is Madical Examiner must be multied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	- 14. Race - Amer Black, White Specify: Whi	e, etc.
Maryland 21215-0036	i 2 should be filed within 72 hc h and Mental Hygiene. I is marked other than "natui traumatic svant, II e M. Lical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation rade completed) College (1-4or	(Give 5+)	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	king	16b. Kind of Business/I Own Home	ndustry
2	Hygie Hygie ther t		10 17. Father's Name (First, Middle, Las	t)	Homen	naker	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
lan	id be ental ked o	To Be	Unknown Green					known	,	
ary	and M s mar		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	and Number or Rui	ral Route Numbe	er, City or Town, State, Z	ip Code)
	and 2 ealth n 27 i		George G. Lach / So	on				-	ce, MD 21229	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is sny injury or other tra <u>once.</u>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Spec			osition (Name of matory or other place ke Cremat	(e)	May 3 2005	20c. Location - City or 1 Beltsville,	
Balt	permit. Departition of the portion o		21. Signature of Funeral Service Lite	ensee M	C	2. Name and Address remation 6 717 Green	and Funera		natives Baltimore, Ma	aryland
8760,	death certificate be executed e attending physicien and d for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate and shock that include the cause (Disease or injury that initiated events resulting in death) Last	a	d the death. Do not entine. And Sublemants a consequence of): a consequence of): a consequence of):	·				Approximate Interval Between Onset and Death
P.O. Box 68	ath certific ittending p or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delin Month	very Day Year
	requires that the de een signed by the a nould be detached t		Part II. Other significant conditions	contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.		obacco use contribute to ⁄es 2 ☑No 3 ☐ Pro	
Division of Vital Records,	The law ete has b page 2 sl	Completed						1 Tes	prior to c death? 2 ☑ No 1 ☐ Yes	opsy findings available ompletion of cause of
Σ.	Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Classic	ent 2 ER/Outpatier	nt 3 DOA Oth	er: 4 D Nursing Mr		<i>ne)</i> dence 6 □Other <i>(Spec</i>	
sion of	ng fter	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		f 28c. Injun Worl	y at		now injury occurred	iry)
Divis	itel or Att rs efter d ei Direct led in by t	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of In building, e	jury - At home, farm, str tc. (Specify)	reet, lactory, office		28f. Location (S City or Tow	Street and Number or Rui vn, State)	rai Route Number,
	To the Hospitel or Attendity within 24 hours efter death. To the Funerel Director; A completely filled in by the funerely	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	thysician: To the best iminer: On the basis of and manner st	of examination and/or in	vestigation, in my o	pinion, death occur	red at the time, o	cause(s) and manner as date and place, and due	to the cause(s)
	With To T	2	29b. Signature and title of certifier	Via		29c. Licens			29d. Date signed (Month	
,	21		30. Name and address of person who	annulated sever of	de site (tree 200) (Tree	Deinel	1865		5/2	15
•	ン		Rrn 206 8 2	A .	Contain (1900,	rect	Baltin	ae, l	md 21-	205
	Sta Regista	-	31. Date filed (Month, Day, Year)	32. Regist	rar's Smature	- Specie	i j			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No." 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 Dara Marc /Medical 4c. County of Death Facility Name (If not institution, give str 4b. City, Town, or Location of Death Examiner bullstown Mor Date of Birth (Month, Day, Year - 26 - 40 Birthplace (State or Foreign Country)
 A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hr **Funeral** Days 1 □ M 2 1 F Months Hours Min. Director 0 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehov Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? ច Itame 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [V] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Specify. BIACK Completed by 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) item 27 is marked other then "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-1 College (1-4or)5+) if Health and Mental Hygiene item 27 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Illiton Thomas ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and West ber or Rury Houte Number, City or Town, State, Zip Code) Kandal Hown MD Date 20c. Location - City or Town, State 20a. Meliod of Disposition Mutchell JR (D 6407 L be Place of Disposition (Name of Husband) permit. Peges 1 Depertment of h Important: If its eny Injury or ot 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wayn Corene Funcial 21. Signature of Funeral Service Licenses Randallotoning MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ereba /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 3 Ectopic pregnancy for Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 2 🗆 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2□ No filled in by the funeral director, 25. Was case referred to medical examine?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1___Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28c. injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred : After I 5 Pending investigation Found \mathbf{a}^{M} 1 🗌 Yes 2 Accident
3 Suicide 2 No death 03/09/2005 Subject fell Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after o determined 4 Homicide 6407 Liberty Rd., Balto., MD Hospital at home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 3 2005

DHMH 17 Rev 1/2001

5401

Old Can

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MckINLEY, BEATRICE Baltimore, Maryland 21215-0036

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
	State of Maryland / Department of Health and Mental Hygiene Item 19a per fh G843 5-4-05 tas
d	Item 19a per in G843 5-4-05 trass of Death

			1 - State Amend Item 19a	State of Maryland per fh G843	/ Departmen 5-4-05 Certificat	t of Health and e <i>of Death</i>	d Mental Hygier Reg. N	ne te	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	EATRICE A	ICKINL	τΥ	2. Date of Death Month	2005 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give so	reet and number)		TOWN, or Location of Di	eath	c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last		1 Year If Under 24 I	Hrs. 8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign Intry) CAROLINA
	nyland show		Usual Residence of Decedent 10a. State 10b. County		Town or Location	20-			10d. Inside Oity Limits
	h the Ma or 28e-1 o	Director	10e. Street and Number	2	SACTIM:	Code		Citizen of What Cou	'/1
	eath wit	Funeral D	800 SAINTOUN 11. Marital Status	STANS KO. 2. Was Decedent Eyer in U.S.	AD 13 Was Decer	2/2/		14. Race - Ameri	. H.
980	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28e-f ehow event, the Medical Exam armust be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?/ 1 Yes 2 M No If Yes, Give Year or Dates:	If Yes, spec	dent of Hispanic Origin? offy Caban, Mexican, Pu 21 No <i>Specify:</i>	uerto Rican, etc.)	Black, White	
1215-0036	within 72 h lene. than "natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	life. DO NOT us	rk done during most of	working	Kind of Business/Ir	
Maryland 21		To Be Co	17. Father's Name (First, Middle, Last)	HEDGE DET.		18. Mother's	Name (First, Middle, Maid	en Sumame) KICHAKT	SON
Mary	and and sm		19a. Informani's Name/Belationship (Typ. Lula Guthrie			(Street and Number of	r Rural Route Number, City ANS RIAD	y or Town, State, Zi	p Code)
ore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. Plac	ee of Disposition (Nar eetery, crematory or o	ther place)	Date 20c.	Location - City or T	own, State
altimore,	그 문 원 등		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Ligense	1 CED.		EMEFERY :	7.05 BA	REENER	MARYCAND WERAL HM.
Ä	Depa Impo		> Vauch	yrise.	4905	JORK ROA	D BACTIMA	RE, MAR	
	Physician		23a. Part1. Enter the disease or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition			e or dying, such as care LURE	diac or respiratory arrest,		Approximate Intervat Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequer		CORC			
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	,				
90,	cate be executed physician and the burial-transit	ı Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer		STRUCTI	on.		
68760,	uficate b g physical as the b	edicai	d						
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No 9 ☐ Unknown	c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pr			23d. Date of deliv Month	rery Day Year
s, P.O	res that the de igned by the a be detached	by Ph	Part II. Other significant conditions con	_	ng in the underlying c	ause given in Part I.		o use contribute to	t. 1
ord	w require been si should t	eted	DIABETES MELL	TITUS				1	bably 4 Unknown
of Vital Records,	ysicien: The law is certificate has director, page 2:	Completed					24a. Was an autopsy performed 1 Yes 2 7	prior to co death?	opsy findings available ompletion of cause of
f Vit	ysicier is certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☑ Inpatient 2 ☐ EF	VOutpatient 3 DC	Other	Death (Check only one) Ig Home 5 Residence	6 □Other (Speci	(fy)
o uoi	anding Ph ath. or: After th		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of 2 Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory	r, office	28f. Location (Street City or Town, Sta	and Number or Rur ate)	al Route Number,
	he Hospi n 24 hou he Funer pletely fill	edicai	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occurred n and/or investigation	at the time, date and pl , in my opinion, death o	ace, and due to the cause occurred at the time, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
	Within Com	Σ	29b. Signature and title of certifier MARW	AN ABOUGERG	I, M.D. 290	RES 000	29d. [Date signed (Month)	
	5		30. Name and address of person who con	npleted cause of death (Item 2: CRGI, 600D	3a) (Type, Print) SAMARIT	AN HOSPI'	TAL, BALTIA	HORE, HD	•
	Sta	ite	31. Date filed (Month Day (Year) 4 21	32. Figistrar's Signatur	La de de				

			For State Registrer	State	of Maryla		artment of H		Mental Hyg	jiene	prog.	IEOEI
			Decedent's Name (First, Midd	lle, Last)				-	2. Date of Dea	th	<u> </u>	3. Time of Death
	Physicia		Jaco	ob	Ma	i			Month April	Day 1	ear ear	9:50 P M
	/Medic Examin		4a. Facility Name (If not institution	on, give street and n	umber)	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or	Location of De		4c. County of	Death	J.50 I
			Genesis Herita	age Merid	ian Edl	ercare	Dunda	lk		Bal	timo	ore Co.
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birth	Year)	9. Birthpl Count	ace (State or Foreign
ш	Director		213-03-1831	1 % ☐M 2□F	97	Yrs.	Nontris Days	TIQUIS IVI	Dec. 2	7, Year) 27, 1907		/land
	pur *	}	Usual Residence of Decedent 10a. State 10b. Count		10c (City, Town or Lo	reation				1/	d. Inside City Limits
	sho	5	Tou. State	•		ony, round to	Joanon	_			1	1 ☐ Yes 2 ☒ No
	he N	Director	Maryland 10e. Street and Number	Baltimor	e		104 7'- Code		oundalk	10g. Citizen of Wh	-1.0	
	with (10f. Zip Code	21222		United S		
	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show the Mcdical Examination rolling at the Mcdical Examination rolling at	Funerai	7825 Deboy 7	Ave.	cedent Ever in	11	Was Decedent of Hi		/Specify Ves or No-			
	ter d	in in	1 Never Married 2 Ma	Armed		0.0.	If Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black,	White,	
936	urs at	by	3√2 Widowed 4 □ Divorce	If Yes (Bive		1☐ Yes 2X No	Specify:		Specify:	Wh	ite
21215-0036	2 ho	Completed	15. Decede	nt's Education	0	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busi	ness/Ind	ustry
215	hin 7	ple	Elementary/Secondary (0-12)	est grade complete	(1-4or 5+)	life.	kind of work done of DO NOT use retired	uring most of v)	vorking			
2	od wil	Con	6 Years		<u> </u>	Mi	llwright			Steel		ustry
pu	at Hy d oth	Be (17. Father's Name (First, Middle	, Last)					lame (First, Middle,	Maiden Sumame,		
yla	Men Men arke	ပ္	William Mai					Julia	a Goetz			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "netural; or items 23e or 28e-f show other treumatic event, the Mcdical Examinar must be rediffied at		19a. Informant's Name/Relation			1	ng Address (Street a B Deboy AV		<i>Rural Route Numbe</i> ndalk, Mai		tate, Zip 2122	_ '
	1 and 2 Health em 27 I		Shirley Szym	anski (Da			osition (Name of	ve. Dui	Date Date			
Ö	Pages nent of Hant of Hant: If ite		20a. Method of Disposition ½□ Burial 2 □ Cremation		m State	cemetery, cre	matory or other plac	,		20c. Location - C	-	
Baltimore,	permit. Pag Department Importent: I any injury o		' 4 □ Donation 5 □ Other (H		ll Mem. (-	Middle 1		
Ba	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service	Consee		2			al Home o			
200	_		23a. Part1. Enter the disease, of	or complications tha	t caused the de	ath. Do not en			Dundalk,		3 21	222 Approximate
ı	3 11		shock, or heart failure. Lis Immediate Cause (Final	st only one cause ur	Ach line.	OF	CAE I	EL.	TEO		French	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. 9	o (or as a cons	7 KL	VI_ L	1-1-	1 10	01		(DAI)
3	Examiner	. [1	NF	7 1 4	ONIA				1	244A 1
	Same	Je.	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a cons	equence un.		\	Λ.			0-10
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 CH	RON	1C0	BSTRUC	TIVE	PULMO	MARY		
0	e exe ien ar urial-t	Ë	resulting in death) Last	Due t	o (or as a cons	equence of):			DISE	ASE'	1	075/15
8760,	licate be executed physicien and s the burial-transit	dical		d					-			
9	leath certific attending p	a a	IF FEMALE:	220 Hugo	udoom o of pro-						-	
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of preg birth 2 Fe gnant at time o	etal death 3	Ectopic pregnancy			23d. Date Mont		ny Day Year
o.	that the de ed by the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Uni		rueaur 5	Other (specify)					
٩	that the		Part II. Other significant condit	tions contributing to	death but not r	esulting in the u	inderlying cause give	en in Part I.	23e. Did to	baceo use contrib	ute to th	e cause of death?
rds	tuires n sign	d by	SENII	E	DEM	LEN	TLA.		1104	es 2 □ No 3	☐ Proba	abiy 4 Dunknown
Records,	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Completed	ATRIAL	FIBR	ILLA	T10	N		24a. Was a		ere autop	sy findings available
Re	The lav	mo		, ,,,,,	(0-1)	, (,			- autop perfor	sy pri med? de	or to con ath?	npletion of cause of
Vital		Be C	25. Was case referred to medic	al				26. Place of E	1 ☐ Yes Seath (Check only or			2 NO
<u>></u>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 [Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Othe	nr 1	Home 5 ☐ Resid		(Specify)
u of	Ph 0 0		27. Mann of Death		te of Injury onth, Day Year)	28b. Time of	of 28c. Injun	at	28d. Describe h	ow injury occurred	t	
io	Attending r death. sctor: After by the fune	atic	2 Accident inves	tigation				Yes 2 □ No				
Division	of or Attending after death. I Director: Afte d in by the fund	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 286. Pla	ce of Injury - Al	t home, farm, st cify)	reet, factory, office		28f. Location (S City or Tow	itreet and Number In, State)	or Rurai	Route Number,
	urs a											
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1 Certify (Check only 2 Medics	Il Examiner: On the	basis of exami	rnowledge, dea ination and/or ir	th occurred at the time execution, in my of	ne, date and pla pinion, death oc	ace, and due to the occurred at the time, o	ause(s) and mani date and place, an	ner as sta d due to	ated. the cause(s)
	o the	Me	29b. Signature and title of dertif	ier	anner stated.		29c. License	number/		29d. Date signed ('Month, L	Day, Year)
	⊢ ≯ ⊢ ŏ		Har	by the	1	MA		711	160 A	PRIL:	30	2005
	of		30 Name and address of perso	n who myleyed ca	se of leath (II	tem 23an Type	Pr60 (110_	AR	TCHI	- HIG	HL	LAY.
10)		MANUT	-2/14	भाग ।	BALT	IMORE	MA	RYLAN	0 21	22	5.
	Sta		31. Date filed (Month, Day, Yea		Registrar's Sig	mature	N. A.					
	Regist	ar	MAY 0	4 2005	Beer.	15 A	SALL!					

		Fica		Department of Lockhood	•	
		1_ State	State of Maryland /	Department of Health and I	vientai Hygier	ne
		Registrar		Certificate of Death	Reg. I	The second secon
Physic	cian	Decedent's Name (First, Middle				Oay Yeer 3. Time of Death
/Mec		DHENDA	MATTHEWS	14 C) T		30, 2005 2150 P M
Exam	iner	4a. Fecility Name (If not institution	/II	4b. City, Town, or Location of Death		o i.
		5. Social Security Number	6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Parto 9. Birthplece (State or Foreign
Funera Directo		216-42-0454	1□M 2NF 59	Yrs. Months Days Hours Min.	Month Day, Yes	145 Many and
		Usual Residence of Decedent				
nylan ihow		10a. State 10b. County	,	own or Location		10d. Inside City Limits 1 ☐ Yes 2 1 No
e Ma	5	/	ldo. Win	dsor Mill		
If I I I I I I I I I I I I I I I I I I	Director	10e. Street and Number	nl	10f. Zip Code	10g. (Citizen of What Country?
ath v	ia	ts ractor	Place	21244		14. Race - American Indian,
er de Itam	Funerai	11. Maritat Status 1 □ Never Married 2 □ Marri	12. Was Decedent Ever in U.S. Armed Forces? ned 1 □ Yes 2 ☑No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
irs aft	by	3 Widowed 4 Divorced	If Yes, Give	1 ☐ Yes 2 1 No Specify:		Specify: Black
2 hou	e	15. Deceden	it's Education 1	6a. Decedent's Usual Occupation	16b.	. Kind of Business/Industry
Pin 7	be	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	rking	
gien gien	Completed by	12	4	unalyst		Government
ylaila Z i Z ould be filed with Mental Hygiene. arked other the	Be	17. Father's Name (First, Middle,	Last)		ne (First, Middle, Maid	len Sumame) I /
Idi yidiild Z. I.Z. 1.2-0000 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. Is marked other than "natural", or Itams 23e or 28e-f show aumatic svent, the Medical Examinar must be indiffed at	ပု	Nelson	Parnes	Darbo		Thews
2 sho		19a. Informant's Name/Relations	thip (Type, Print)	9b. Mailing a tres (Street and Number or Ru		1. 0 . 411
1 and 1 health Health ther tr		20a. Method of Disposition	1Thews misband 20b. Place	of Disposition (Name of	Date 2 c	Location - City or Town, State
Pages nent of nnt: If its		1 Burial 2 Cremation	3 □Removal from State / ceme	etery, crematory or other place)		16 41
	4	' 4 □ Donation '5 □ Other (S 21. Signator of Funeral Service		enmount (remotor) May	7 2005 6	ce DA
Dermit. Departr Imports sny inj	9300) (en las	(Donday	Carper G. Longland	F. Bala	W. 21217
		23a. Part 1. Enter the disease, or	complications that used the death. [Do not enter the mode of dying, such as cardiac	c or respiratory arrest,	Approximate Interval Between
Physicia	2	Immediate Cause (Final	only one cause on each line.	77 C202 AUTOM	11-000	Onset and Death
/Medica	_	disease or condition resulting in death)	Due to (or as a consequen	OTIC CARDIOUASCULAR	DISEASE	10 years
Examine	r	Cognostially list conditions	b			
p #	ne ne	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a consequen	ce of:		
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			
BOX 00/00, eath certificate be executed attending physicien and for use as the burial-transit	calE		Due to (or as a consequen	c o oi).		
ob/	edica		d			
Certifi Certifi ding	Me	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery
Geath certifica e attending phid for use as the	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal de	ath 3 ☐ Ectopic pregnancy		Month Day Year
5	Physician/M	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9☐ Unknown			
- C -	by Pi	Part II. Other significant conditi	ions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
w requires been sign should be					1 🗆 Yes	2 No 3 Probably 4 Unknown
eco lawre as bee	plet				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
VITAI MEC sician: The law certificate has b	Completed				performed	? death?
r VITAI ysician: Tysician: Tis certifical	Be	25. Was case referred to medica examiner?	al		ath (Check only one)	
Of V Physic rthis ce	2	1 XYes 2 □ No				e 6 □Other (Specify)
On C ding P After t funera	on:	27. Manner of Death 1 SNatural 5 ☐ Pendi	ing (Month, Day Year)	b. Time of 28c. Injury at Work?	28d. Describe how in	njury occurred
ISIO ttendii death. ctor: A y the fu	cat	2 Accident invest	igation	M 1 Yes 2 No	206 t continu (Ctmo)	t and Number or Rural Route Number,
DIVISION I or Attending after death. Director: Afte	Certification:	4 Homicide determ	nined 28e. Place of Injury - At home building, etc. (Specify)	s, rarm, street, ractory, office	City or Town, Si	
UNISION Of VITA To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 ☐ Certifyi	ing Physician: To the best of my knowle	dge, death occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
e Ho 24 h e Fui	Medical	(Check only one) Medica	Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occi-	urred at the time, date	and place, and due to the cause(s)
To th To th comp	×	29b. Signature and title of certific	er	29c. License number	29d.	Date signed (Month, Day, Year)
, (/	Hatzillet	MIN DEPUTY	018/067	MA	Y2,2005
2100	1	30. Name and address of person	who completed cause of death (tem 23	Ba) (Type, Print)		
F 2		I WILL WILL	111- NA 1-T-1	11-4110-11-41 00	Willo Ma	ryland 21093
Y		I Milit Milit	I LECTO IN 1) CIC.	MARCHITCH CHINE	o medical	The state of the s
	State strar	31. Date filed (Month, Day, Year	r) 32. Registrar's Signalur	Ba) (Type, Print) whole Hill CT. Luth or	o me, th	t and the same of

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LLOVIS W. MORRIS ZOOS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner JOHNS HOPKINS BMY VIEW Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Months Days 78 252 30 567 Z Usual Residence of Decedent APRILIZ 1927 Director Ga Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Wedical Examinar must be notified at Baltimore 1 ☐ Yes 2X No Funeral Director BATIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen ol What Country? USA KUMO esuc 21222 1741 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ANo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Steel 11 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie Andrews Willie Baker Morris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is any injury or other tra wife Dundalk Md. 21222 1741 Leslie Rd. Marie Morris 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Jesus 20a. Method of Disposition Date 20c. Location - City or Town, State May 5, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk ¹ 4 □ Donation 5 □ Other (Specify) 2005 Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 21. Signature of Euneral Service Lic th'Em 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final cwy BODY Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown IFBRILLATION Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No within 24 hours after death.

To the Funaral Director: After thin completely filled in Example. Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No ² 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 333/6

State Registrar 5505

Hopkin Boyview Circle Baltimon Moziczy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

32. Registrar's Signature

Bellantons

31. Date liled (Month, Day, Year)

MAY 0 4 2005

McKINNEY

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 29, 2005 **Physician** Edwin Henry Moran 5:10 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Household of Angels Severna Park Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 29, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Days Min 577 18 3872 86 YES. June 1918 New York, Director Usual Residence of Decedent 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23s or 28a-f show any injury or other traumatic event, the Medical Event instrumb to notified at once. 10a. State 10d. Inside City Limits 1 ☐ Yes XXNo Director Marvland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Arundel Beach Road 21146 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status XXYes 2 No WWII if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Local #132 Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpenters Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Augustine Moran Louise Mary Mulligan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Henrietta J. Trundle (Sister IN 802 Coxswain Way, Unit 302, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) May 3, 2005 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Suitland, Maryland 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Cer 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Rd, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SF PSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner BLADDEN Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit NEURO GENIC that initiated events nding physician and resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No rmeg? 2☑ No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Diractor: completely filled in by the f 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 24768 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) William Dabbs,M.D. 277 Pensula Farm Road, Arnold, MD Day, Year) 0 4 2005 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:00 PM Wallace Merryman 2005 May 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 781 Glen Avenue Ellicott City Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F 212-30-8131 76 DEC. 6, Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or Items 23a or 28a-1 abov treumatic event, the Medical Exeminar must be multified at MD Howard Ellicott City 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 781 Glen Avenue 21043 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Patapsco Associates 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Importent: If tiem 27 is marked oth any injury or other treumatic even page. Be John Stanley Althea Rose Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David Merryman - son 781 Glen Avenue, Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 5/5/2005 Laurel, MD Baltimore Wash. Crem. 21. Signature of Fundral Service Licensee Gary L. Kaufman Funeral Home @ Meadowrid e MP, Inc. VIVA 7250 Washington Blvd., Elkridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the diserce, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Physician Years /Medical Due to (or as a consequence of): Examiner Years Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Hypercholesterolemiz Years and Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760, Hypertension Years by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown been sig Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Ž□ No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 ☐ Yes 2X No ۵ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funerel C

completely filled i Hospiter 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of completed cause of death (Item 23a) (Type, Print) ne and address of pe 4801 Dorsey Hall Drive Sley steven 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2005

DHMH 17 Rev 1/2001

ysicia	ın	1. Occedent's Name (First Middle, I Sherri L. Myers Cherry Lypn Myor	Last)						2. Date of D	Da		ear	3. Time of Death
ledica amine		Sherry Lynn Myer 4a. Facility Name (If not institution, g				4b. City, To	own, or Loc	ation of De	April	1	2005 County of		04:04 a.™
<i></i>		Franklin Square	Hospital			Ros	sedale	е		F	Baltin	ore (County
eral ctor		5. Social Security Number 6 220-02-6453	. Sex 1 7. Age 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	9 (In yrs. last	birthday) Yrs.	If Under 1 Months I		Under 24 H lours Mi		Birth Day, Year) 4, 1	975 ⁹	Birthplace Country) Flori	e (State or Foreign da
othar traumatic evant, illia medical illiati mat ke i kiliner at	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	ocation						10d.	Inside City Limits
	ctor	Maryland n/a	:	Ba]	ltimo	ore							1X Yes 2 No
	ai Dire	10e. Street and Number 525 South Kenwood	od Avenue			10f. Zip C	ode 2122	4		_	tizen of Wha Jnited		
	Completed by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 M N If Yes, Give Year or Dates:		- 1	Was Deceder If Yes, specify 1 \(\text{Yes} \) 2	-	nic Origin? lexican, Pu	(Specify Yes or ferto Rican, etc.)	No-	14. Race - Black, Specify:	White, etc.	
	leted	15. Decedent's (Specify only highest)	Education grade completed)	1	6a. Dece (Give	dent's Usual (kind of work DO NOT use	Occupation done durin	n ng most of v	vorking	16b. K	(ind of Busin	ness/Indust	itry
	omo	Elementary/Secondary (0-12)	College (1-4or 5	+)		sabled	11811184)			r	never	worke	ed
	Be	17. Father's Name (First, Middle, La		,					lame (First, Midd				
	ဠ	Richard Edward M 19a. Informant's Name/Relationship	-		10b Maili	ina Address (is Ann W Rural Route Nurr			ato Zin Co	200
		Kenneth Woolridg			525	5 South	h Ken	wood 2	Avenue,	Balti	imore,	Mary	yland 2122
1		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3	□Removal from State			osition (Name matory or oth			Date		ocation - Ci		
		`4 □Donation 5 □ Other (Spe	ocify)	Bayv		Cremato							aryland
once.		21. Signaturé of Funeral Service/Lin	cepsee.		22				Hubbard			9 3 3 5 5 5	and 21229
an		23a. Part 1. Enter the disease of conshock, or heart failure. List or Immediate Cause (Final	on livations that caused ny ne cause on each lin	the death. I	Do not en	ter the mode						Ar	
1	iner	disease or condition resulting in death)	a. Methado Due to (or as b. Due to (or as	ne Int a consequen	coxic		of dying, su	uch as card	iac or respiratory	arrest,		Int	oproximate terval Between nset and Death
r	n/Medicai Examiner	disease or condition	Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	ne Int a consequen a consequen a consequen of pregnancy	coxic ace of):	ation		uch as card	iac or respiratory	arrest,	23d. Date o	Int Or	terval Between
er	cai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c. Due to (or as d.	ne Int a consequen a consequen a consequen of pregnancy	coxice of): ace of): ace of):		gnancy	uch as card	iac or respiratory	arrest,	23d. Date o Month	Introduction of delivery	iérval Between nset and Death
r	by Physician/Medicai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1. Yes 2 No	Due to (or as b. Due to (or as c. Due to (or as c.)	ne Int a consequen a consequen of pregnancy 2 ☐ Fetal de	coxic lice of): lice of):	□Ectopic prec	gnancy cify)		23e. Di	d tobacco	Month use contribu	of delivery	iérval Between nset and Death
er	Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as c.)	ne Int a consequen a consequen of pregnancy 2 ☐ Fetal de	coxic lice of): lice of):	□Ectopic prec	gnancy cify)		23e. Di	d tobacco Yes 2 as an topsy rformed?	Month use contribute No 3 24b. We	of delivery Da ute to the c Probable re autopsyor to compliant?	rérval Between nset and Death And Pear Year cause of death?
per	Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as.	ne Int a consequen a consequen of pregnancy 2 Fetal de time of death ut not resultir	coxic lice of): lice of): // sath 3[h 5]	□Ectopic pred □ Other (spec	gnancy cify) use given in	n Part I.	23e. Did 1[24a. Wi au pe 1[Xes	d tobacco Yes 2 as an topsy fromed? 2 \(\) No	Month use contribu □ No 3 24b. We price des	of delivery Da Delivery Delivery	ay Year cause of death? ly 4 Unknown r findings available letion of cause of
er	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. Due to	ne Int a consequent a consequent of pregnancy 2 ☐ Fetal de time of death ut not resultir	coxic conditions of the condition of the	□Ectopic pred □ Other (spec	gnancy cify) use given in 26 A Other: ic. linjury at Work?	n Part I. 6. Place of [23e. Di 1 24a. Wi au pe 1 L Ves	d tobacco Yes 2 as an topsy formed? 2 \(\) No (y one)	Month use contribute P No 3 24b. We price descent	of delivery Da ute to the c Probable re autopsy or to compliatin? I Yes 2 (Specify)	ay Year cause of death? ly 4 □Unknown y findings available letion of cause of
er	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequent a consequent a consequent of pregnancy 2 Fetal de time of death ut not resulting the consequent acceptance of the consequent acceptance of the consequent acceptance of the consequence of the	coxice of): lice of): lice of): ly ly ly ly ly ly ly ly ly l	□Ectopic prec □ Other (spectant) underlying cau ant 3□ DOA of unk 286 M	gnancy cify) use given in 26 A Other: C. Injury at Work? 1 \(\subseteq \text{ Yes} \)	n Part I. 5. Place of E	23e. Di 1 24a. Wi 2 a pu 1 2 e a th (Check on) 3 Home 5 Re 28d. Describ	d tobacco Yes 2 as an topsy rformed? 2 No y one) asidence how inju	Month use contribution of the second of the	of delivery Da Delivery Da Probably re autopsy or to compliant? (Specify)	ay Year cause of death? ly 4 □Unknown y findings available letion of cause of
ונוופומ חופטנטי, page 2 מונטמום סים מפנמנוופט וכן נפס מפ זוני בעוומי יומויסור	Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as. b	ne Int a consequent a consequent a consequent of pregnancy 2 ☐ Fetal de time of deatt ut not resultir ut not resultir ent 2 ☐ ER ry y Year) 28 ury - At home c. (Specify) of my knowle f examination	coxic co	Ectopic pred Other (spectal of unk 286 M	gnancy cify) use given in 26 A Other: Work? 1 Yes office	n Part I. 5. Place of € 4 □ Nursing 2 X No	23e. Did 24a. Wi a pe 1 Dives Death (Check only 3 Home 5 I Re 28d. Describ 28f. Location City or 1 ESSEX,	d tobacco Yes 2 as an topsy formed? 2 No y one) asidence how inju (Street a. own, Stat Mary	Month use contribution of the contribution of	of delivery Da ute to the c Probable re autopsy or to completth? (Specify) Un Grant Rural Ru Fondu	ay Year cause of death? ly 4 Unknown of findings available letion of cause of No No No No No No No No No
	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to	ne Int a consequent a consequent a consequent of pregnancy 2 ☐ Fetal de time of deatt ut not resultir ut not resultir ent 2 ☐ ER ry y Year) 28 ury - At home c. (Specify) of my knowle f examination	coxic co	Ectopic prediction Other (special or and all DOA of unk 286 M treet, factory, ith occurred at nivestigation, in	gnancy cify) use given in 26 A Other: Work? 1 Yes office	n Part I. 5. Place of E 4 □ Nursing 2 X No date and place on, death or	23e. Did 24a. Wi a pe 1 Dives Death (Check only 3 Home 5 I Re 28d. Describ 28f. Location City or 1 ESSEX,	d tobacco Yes 2 as an topsy formed? 2 \(\) No y one) ssidence e how injuit (Street a fown, Start Mary ne cause(se, date and	Month use contribution of the contribution of	of delivery Da ute to the c Probably re autopsy or to compliath? Yes 2 (Specify) un or Rural Ru F ond u	ay Year cause of death? iy 4 Unknown r findings available letion of cause of No No k cause Number, Lac Road ad. e cause(s)
ind er	Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to	ne Int a consequent a consequent a consequent of pregnancy 2 ☐ Fetal de time of deatt ut not resultir ut not resultir ent 2 ☐ ER ry y Year) 28 ury - At home c. (Specify) of my knowle f examination	coxic co	Ectopic pred Other (spectal of unk 286 M and street, factory, whether the occurred at the occu	gnancy cify) use given in 26 A Other. ic. Injury at Work? 1 □ Yes office	n Part I. 5. Place of E 4 □ Nursing 2 X No date and place on, death or	23e. Did 24a. Wi a pe 1 Dives Death (Check only 3 Home 5 I Re 28d. Describ 28f. Location City or 1 ESSEX,	d tobacco Yes 2 as an topsy is 2 No y one) sidence how inju (Street a. own, Stat Mary he cause(se, date an	Month use contribution 2 No 3 24b. We price dead of the price of the	of delivery of delivery of Da ute to the c Probably re autopsy or to compliatin? Yes 2 (Specify) un or Rural Ra Fondu er as state d due to the	ay Year ause of death? ly 4 Unknown of findings available letion of cause of No lk lac Road ad. le cause(s) y, Year)

			For State Registrar	State of	Maryla	•	artment of l				giene Reg. No.	2005	15	061
	Diii		1. Decedent's Name (First, Middle	, Last)						2. Date of Dea	ath Day	Year	3. Time of	Death
	Physici /Medio		John Woodford M	lullen						April			4:00	A M
	Examin		4a. Fecility Name (If not institution	, give street and num	nber)		4b. City, Town,	or Location	of Death		4c. C	County of Deat	h	
			Manor Care-Poto				Potoma					ntgomer	-	
	Funeral		5. Social Security Number	6. Sex 12 M 2 ☐ F	7. Age (In yrs 79	s. last birthday) Yrs.	If Under 1 Year Months Days		Min	8. Date of Birt (Month, Da	v. Year)	Co	nplace (State o untry)	-
	Director		579-26-3892 Usual Residence of Decedent		- 19	113.				March 1	11,19	26 Wasi	nington	, DC
	land m		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside C	ity Limits
	Mary -f sh	ţo	Maryland Montgo	mery	Si	lver Sp	ring						1 🗆 Yes	2 √ No
	r 28a	Directo	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?	
	h witt		3927 Joliet Str	eet			20906				Uni	ted St	ates	
	deat	Funerai	11. Marital Status	12. Was Dece Amed Fo		U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Or	igin? (Spe	city Yes or No	- 14	4. Race - Ame Black, White		
9	or Its	F	1 ☐ Never Married 2 ☑ Marr	ied 1X Yes	2 No WO	rld	1 □ Yes 2 ☑ No							
21215-0036	72 hours after death with the Maryland natural', or Itams 23s or 28s-f show disal Examinat must be indiffed at	d by	3 ☐ Widowed 4 ☐ Divorced		e ites:War	11						Specify: Wh		
5-	nati	Completed	15. Deceden (Specify only highe			(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	st of working	ng	16b. Kind	d of Business/	industry	
12	within than the Me	щ	Elementary/Secondary (0-12)	College (1	-4or 5+)		Firefigh	,			Cirri	1 Serv	ico	
d 2	ther rther	e C	17. Father's Name (First, Middle,	Last)		р.С.	rirerigi		er's Name	(First, Middle,			rce	
an	ld be ental ked c	To B	John Woodford M	ullen				Ran	ouhi	Kalous	dian			
Maryland	es 1 and 2 should be f of Health and Mental b litem 27 is marked of r other traumatic ave	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stree	t and Numb	er or Rura	l Route Numbe	er, City or	Town, State, Z	(ip Code)	
	and 2 ealth a n 27 ls	Ш	Imogene Mullen/	Wife		3927	Joliet S	treet	, Sil	ver Sp	ring,	MD 20	906	
J.	of Herm		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of	1	D	ate	20c. Loc	ation - City or	Town, State	
E	Page Jent Int: If		1 ☑ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		State (Cemete	natory or other pla Heaven Yv		May 4 2005	•		er Spr	rng,	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		21. Signature of Funeral Se vio	1 11/	100689	Ko	Name and Addr ckville, Rockvil	inc. Inc. 1e, M	yRobe 300 aryla	rt A.] West 1 Ind 208	Pumph Monte	rey Fu	neral H Avenue,	Home/
			23a. Part J. Enter the disease, or shock, or heart failure. List	complications that conty one cause on e	aused the dea	ath. Do not ent							Approximat Interval Bet	tween
	Pnysician		Immediate Cause (Final disease or condition	Chr	onic L	vmphocy	tic Leuk	emia					Onset and	Death
	/Medical		resulting in death)		or as a conse			· · · · · · · · · · · · · · · · · · ·						
	Examiner	L	Sequentially list conditions,	0.		's Dise	ase							
	ait sit	Examiner	Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury		oras a cons	ed weak	ness							
_	and and I-tran	хап	that initiated events resulting in death) Last	C.	or as a conse									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit					, ,								
687	ficate physis the	edic		d.										
XO	eath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			-				23	Bd. Date of deli	very	
B.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregn	irth 2 □ Fe ant at time of		∃Ectopic pregnand ∃ Other <i>(specify)</i> ₋	cy				Month	Day	Year
0	t the de by the tached	hys	9 Unknown	9∐ Unkno)wn									
S, P	es tha igned be del	ру Р	Part II. Other significant condition	ons contributing to de	eath but not re	esulting in the u	nderlying cause g	ven in Part	I.	23e. Did te	obacco us	e contribute to	the cause of o	death?
ord	w require been sis									101	Yes 2 🗆]No 3□Pr	obably 4 📜	Unknown
ecords,	e law re has be	Completed								24a. Was autop			topsy findings completion of c	
æ		Com								perfo	rmed?	death?	2 No	
Vital	Physiclan: Th this certificate ral director, pag	Be (25. Was case referred to medica examiner?						e of Death	(Check only o	one)			
of \	Physic this or	2	1 ☐ Yes 2 🔀 No			☐ ER/Outpatier	IL 3 DOA			ne 5 🗆 Resid			city)	
	ding P h. After funera	inol.	27. Manner of Death 1 X Natural 5 ☐ Pendir	9	of Injury h, Day Year)	28b. Time o Injury	We	ork?		28d. Describe t	how injury	occurred		
Sic	Attending r death. ector: After by the fune	icat	2 Accident investi 3 Suicide 6 Could	not be 390 Blace	of Injune . At	homo form at]Yes 2□		28f. Location (S	Stroot and	Number or Pu	ra I Pouto Alum	nhor
Division	l or Atten after deatl Director:	Certification:	4 Homicide determ	ined 286. Flace buildi	ng, etc. (Spec	cify)	reet, factory, office	,		City or Tov		NUMBER OF THE	TALL FLODIES (VDI)	1001,
_	Hospitel 4 hours a Funeral I tely filled		29a. Certifier 1☑ Certifyir	ng Physician: To the	best of my ki	nowledge dest	h occurred at the	time, date ar	nd place. a	and due to the	causa(s) a	and manner as	stated	
		edical		Examiner: On the ba										5)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	1/20.		10		se number				signed (Monti	n, Day, Year)	
)	il -		kuli	VOW	02 /		D2027	4		ı	May 2	, 2005		
17	5/1		30. Name and address of person	who completed caus	e of death (It	em 23a) (Type,	Print)							
1			Kirti Vohra, M.						ring,	Mary1a	and 2	0902		
	Sta		31. Date filed (Month, Day, Year)	MAY 0 4 2	egistrar's Sig	ature	4 dos	W						
	Regist	rar		MAY U & Z	בע כטו	CARREN .	10 /2/	1755						

State of Maryland / Department of Health and Mental Hygiene State Registraramend item 319b per fh g843 \$ # Triff Cost e por Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GLORIA 29 APRIL NAIDITCH 2005 2:00 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4730 ATRIUM VILLAGE BALTIMORE OWINGS MILLS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Day Year)
JUL. 3,1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 ☐ F 75 Yrs. MD 215-22-3085 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural; or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or items 23a or 28a-f show vent. The Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director OWINGS MILLS BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4730 ATRIUM VILLAGE #178 21117 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🕅 No þ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 HOMEMAKER OWN HOME event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MIDDLEMAN SIDNEY SCHRETER REGINA other traumatic 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (State Number or Rural Route Number, City or Town, State, Zip Code) 8525 MT. WILSON LANE - BALTIMORE, MD 21208 BRENT COHN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ö BETH EL MEMORIAL PARK 05/02/2005 RANDALLSTOWN, MD ¹ 4 ☐ Donation 5 Other (Specify) 21. Signature of June 21 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Jervice Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBRAL THROMBOSIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 HUnknown 1 ∏ Yes 2 ∏ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 20 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 2005, 95 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 2-t Main TOVO CV MD 75 51: 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 4 2005 Registrar

			For State Registrar	State of	Maryland	•	irtment of F		Mental H	ygiene Reg. No. 2	100	1 00	0.4
	hysicia		Decedent's Name (First, Middle, Lass)	t) Elsie		Perzin			2. Date of D Month April	Death Day	Year	3. Time o	
	/Medic xamine		4a. Facility Name (If not institution, give	street and numb	er)		4b. City, Town, o	r Location of Dea			y of Death		
			Upper Chesapeake				Bel			1	ford		
	neral ector		5. Social Security Number 6. Social Security Number 1	9X 7. □M 2. 2XF	Age (In yrs. Id 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		irth Pay, Year)	Coun	lace (State o try) Land	or Foreign
			Usual Residence of Decedent						Tay 4	7 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 -		- Laria	
nylan	d'et	_	10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside C	*
he Ma	ouille ouille	Director	Maryland Aber	deen				rford		10a. Citizen of	1415 - 1 0		2 X No
with	Lee	Ö	10e. Street and Number 2419 Carsins Ru	n Road			10f. Zip Code	2100	01	United			
death	ms 2	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13. V	Vas Decedent of F Yes, specify Cubi	lispanic Origin? (Specify Yes or N		ce - Am <i>e</i> ric	an Indian,	
36 after	or te	y Fui	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	MNo		Yes 2 No		erto Rican, etc.)	Speci	nck, White,		
-000	tural Ex	ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Date	9S:	16a Deced	lent's Usual Occup	ation		16b. Kind of E	WII	ite	
27 air.	Wedis	Completed	(Specify only highest gra-	de completed) College (1-4	or 5+\	(Give lite. L	kind of work done OO NOT use retire	during most of w d)	orking	TOD. KING OF E	04311103371110	ustry	
213 213 giene	er tha	Eog	10 Years	Conego (1-4	01347	HO	memaker			Own I	lome		
be fifte	evani	Be	17. Father's Name (First, Middle, Last)						ame <i>(First, Middl</i> Dara Buc		me)		
Maryland 21215-0036 d.2 should be filed within 72 hours att.	marka	၉	Joseph Pluhar 19a. Informant's Name/Relationship (7)	voe. Print)		19b. Mailin	g Address (Street				State Zin	Code)	
Ma Malth ar	itam 27 is merkad other than "nature", or items 23s or 28s-1 show other traumatic evant, the Medical Examinar must be colified at		Mr. Michael Per		(Son)		Carsins						001
ore,	or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	ater Ce	emetery, cren	sition (Name of natory or other place		Date	20c. Location	- City or To	wn, State	
HAS/05 Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Health, and Mental Hygiene.	mportant: any injury o once.		* 4 □ Donation 5 ☑ Other (Specify)(/	Mox		Mem. Par	1				Mary.	land
Balti Departit	any ir	1	21. Signature of Juneral State Property	Int.			Name and Addre uda-Ruck 922 Wise						
	A ₁		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cau	ised the death						4	Approximat Interval Bet Onset and I	tween
	dical		Immediate Cause (Final disease or condition resulting in death)	a. SEV	16RE		STOCE	CEAL	VN6	MONT	1	Onsor and	Dodgii
	niner			Due to (or	as a consequ	ience of):							
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ			0. 1.	1.2 A 1				ed to
Acute A	transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. 36V8			ICOBS	TRUCTU	& Pull	YOMORY	DISTO	SE	
8760, cate be executed		cai E	in the state of th	Due to (or	as a consequ	ience or):				•			
	g phys as the	77		d									
OX Th cent	attending p I for use as	ian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar		Ectopic pregnancy	,			ate of delive	-	
. O . O	the att	O	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nt at time of de		Other (specify)			M	onth	Day [^]	Year
P.C	detached	Physic	Part II. Other significant conditions of	ontributing to deat	th but not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use con	tribute to th	e cause of c	death?
\rightarrow α $^{\circ}$	يَّ مِنْ	ed by		·					1□	Yes 2 □ No	3 🗆 Proba	ibly A	Unknown
	2 sho	Completed							24a. Wa	s an 24b.	Were autop	sy findings	available
E E	page 2	Com							per 1 ☐ Yes	formed?	death?		adae oi
of Vital	5 5	Be	25. Was case referred to medical examiner?	Hospital:			015		eath (Check only	one)			
ž ž	in di	. To	1 Yes 2 No 27. Manner of Death	Hospital: 28a. Date of		ER/Outpatien		4 Nursing	Home 5 Res	how injury occu)	
on of the state of	: Atter the funeral	ation	Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2□No		non injury occu			
SIE Division For Attending	Diractor: in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of	Injury - At ho	mø, farm, stre	eet, factory, office			(Street and Num	ber or Rural	Route Num	iber,
Ditalo	<u> </u>	0											
Division To the Hospital or Attending within 24 hours after death.	声	edical	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be iner: On the basi and manne	is of examinat	wledge, death ion and/or inv	occurred at the tir restigation, in my o	ne, date and plac pinion, death occ	ce, and due to the curred at the time	e cause(s) and m , date and place,	anner as sta and due to	ited. the cause(s	;)
To the I	To the Fun completely	Me	29b. Signature and title of certifier	11			29c. Licens	e number		29d. Date signe	ed (Month, L	lay, Year)	
			1 4 4	the	1		7)2	6171		4/28	120	05	
	5		30. Name and address of person who	completed cause	of death (Item		Print) 0	0516	NDR I	E TOWN	SN 14	D 2/2	204
	Stat Registra		31. Date filed (Month, Day, Year) MAY 4 200	5 See	jistrar's Signa	yre for	de						

		1 - State Registrar		Cer	tificate of	Dealli		Reg. No.	A ,	
Phys		Decedent's Name (First, Middle, Last) Phi	lip	Pois	t		2. Date of De Month April	Day 27, 200	Year	3. Time of Death
1	dical . niner	4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, o	Location of Death			nty of Deat	1
Lxaii	illi (c,	Upper Chesapeake H	ealth		Bel A	ir		H	arfor	d Co.
Funer	al	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birtl	nplace (State or Foreign untry)
Directo		212-32-5238	1 2□ F 70	Yrs.	Widitiis Days	, louis livian		0,1934		ryland
2		Usual Residence of Decedent	100 Cit	y, Town or Lo	nation					10d. Inside City Limits
ırylar show	-	10a. State 10b. County	100. 01	y, TOWITOT LO	Sation					1 ☐ Yes 24 XNo
e Ma 38-1	Director	Maryland Harfo	rd			oppa	T	10g. Citizen	-414/5-4-0-	
iff the or 2	Dire	10e. Street and Number			10f. Zip Code			•		
1215-0036 within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-1 show then "naturel" and Ex. nit of must be netilified at	īa.	200 Bridge Drive		0 10 1		1085	anifu Van as Ne	Unite		tes ncan Indian,
ar de	Funerai	THE THE PARTY OF T	. Was Decedent Ever in U Armed Forces?	.S. 13. V	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)) 14. E	Black, White	
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours afte potament of Health and Mental Hygiens protant: If item 27 Is marked other then "naturel', or ly injury or other treumatic event, the Modific Ex. Dit	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐ Yes 2🖾 No	Specify:		Spe	cify:	White
Por Por	ba	15. Decedent's Educa		16a, Deced	ient's Usual Occup	pation		16b. Kind o	f Business/	
n 72 n m	Completed	(Specify only highest grade of	completed)	(Give	kind of work done OO NOT use retire	during most of work d)	king			
the with i	E E	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Years		Forema	n		Ste	el In	dustry
filed Hygi ther	Ö	17. Father's Name (First, Middle, Last)	Z ICUZS		1020110	18. Mother's Nam	e (First, Middle			
d be antal	9 Be	Samuel Poist, Sr.				Ethel	James			
houl d Me mart	T _o	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street	and Number or Rur	al Route Numb	er, City or To	wn, State, 2	Zip Code)
d 2 s th an treu		Mrs. Barbara Poist		200	Bridge D	rive Jop	pa, Mar	yland	2108	5
Heal Cher		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		Date	20c. Location	on - City or	Town, State
nt of nt of ror or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Control Control Control Description	noval from State	ametery, cren Dak Law	natory`or other pla	4/30/2005		Bal+	imore	, Maryland
it. P. rtme rtant		21. Signature of Funeral Service Licensee		22	Name and Addre	ss of Facility				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked coher than "naturel; or Items 23a or 28e-1 show any injury or other theumatic event, the Maryland at any injury or other theumatic event, the Maryland Escholing Towal be notified at	once	21. 3191111111111111111111111111111111111			Duda-Ruc	k Funeral	Home o	of Dund	alk,	Inc. 21222
		232 Part Enter the disease or complica	ations that caused the deat	h. Do not ent		se Ave. I			rand	Approximate
		23a. Part1. Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final	cause on each line.		7					Interval Between Onset and Death
Prysicia	_	disease or condition resulting in death)			wy in	phoma.				
/Medic Examin	_		Due to (or as a consec	quence of):						2 months
	- L	Sequentially list conditions, b.	Due to (or as a consec	uence of):						
ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury		, , ,						
and I-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):						
ficate be executed physician and sthe burial-transit	a E									
cate phys	edical	d.								
, sath certificate be ex attending physician for use as the buria		IF FEMALE: 230	c. If yes, outcome of pregn					23d.	Date of de	ivery
eath atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of]Ectopic pregnanc] Other (s <i>pecify)</i> _	у			Month	Day Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							_
that the ed by detail	by Physician/M	Part II. Other significant conditions conti	ributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco use d	ontribute to	the cause of death?
sign be							1 🗆	Yes 2	5 3 □ Pr	obably 4 Unknown
he law requires that the death cert e has been signed by the attendin soe 2 should be detached for use	Completed						24a. Wa	s an 24	lb. Were au	itopsy findings available
e lav	a E							ormed?	prior to death?	completion of cause of
: The licate ha	ပိ						1 ☐ Yes	23 170	1 ∐ Yes	2□ No
nysicien: The sistem of the si	Be	25. Was case referred to medical examiner?	spital:	7	- Casa Ot	26. Place of Dea			011 (0	-16.1
Phys r this		1 Yes 2€ No	28a, Date of Injury	ER/Outpatier 28b. Time o	IL 3 DOA	4 Nursing H	ome 5 Hes 28d. Describe			сіту)
ding Ph ding Ph After th	on	27. Manner of Death 1 Natural 5 □ Pending	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No		,,		
JIVISION I or Attending after death. Director: Afte	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	nome farm str		,	28f. Location	(Street and N	umber or Ri	ural Route Number,
l or Atten after deatl Director:		4 Homicide determined	building, etc. (Spec	ify)	eet, lactory, office		City or To	wn, State)		
ospitel hours a unerel [Continue Physic	cian: To the best of my kn	owledge deat	h occurred at the t	ime date and place	and due to the	Cause(s) and	l manner a	stated
6 4 교 등	edical	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	opinion, death occu	rred at the time	, date and pla	ce, and due	e to the cause(s)
To the Hos within 24 h To the Fur	Med	29b. Signature and title of certifier	and mainer stated.		29c. Licen	se number		29d. Date si	gned (Moni	h, Day, Year)
T wit		B 1	- m		D54			4/2	8/01	
. 1		yan -				041		-/-	1	/
100		30. Name and address of person who cor	noleted cause of death (Ite	m 23a) (Type,	Print)			-		
6417	,	(1-11-1-12-1	/ 41/	At.	and Pd	< · + -	200 F	2/10	- Mi	21014
6412	State	111 21	Ah 603	Atu.	good Rd	Suite.	200	Sel Air	, Md.	21014

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Pansy Roberta Parks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Arundel Hospital Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ Days Hours 231-03-2830 91 Yrs Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits worls 10a. State 10b. Count Director 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1380 Becknel Avenue Itams 23a 21113 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mental Expense. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Shirt Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oliver Frank Parks, Sr. Mary Jane Finney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Chaney, Sister 1380 Becknel Ave., Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parksley Cemetery 04/22/05 Parksley, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harman Funeral Service, P.A. 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Is chamic Physician (2) disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) nding physician a use as the burial-Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1 🗌 Yes 25. Was case referred to medical director 26. Place of Death (Check only one. examiner Hospital: 1 Inpatient 2 ER/Outpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No after death. investigation 6 Could not be determined 3 Suicide within 24 hours after de To tha Funaral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and a ss of person who completed cause of death (Item 23a) (Type, Print) 2005 32. Redistrar's Signatura Registra

			For Stata Registrar	State o	of Maryla	•	artment of learning		d Mental Hy	giene Reg. No.	105	15066
	Physicia		1. Decedent's Name (First, Middle, Robert	Last)	L.	P	APPA	S	2. Date of De Month	ath Day	Year 20.5	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, Franklin Squa 5. Social Security Number			s. last birthday		or Location of Do		4c. C	County of Death	
	Funeral Director		217-74-8987 Usual Residence of Decedent	1 AM 2 □ F	7. Ago (m)10	47 Yrs.	Months Days		Min. 10-23	ıy, Year)	MD	untry)
bookeek	f show	or	10a. State 10b. County			City, Town or L						10d. Inside City Limits Y Yes 2 No
d d d	or 28e	Director	10e. Street and Number		INC	JSEGAI	10f. Zip Code			10g. Citize	en of What Co	untry?
t t	ns 23a	Funeral	1207 Primrose 11. Marital Status		edent Ever in	U.S. 13	21237	Hispanic Origin?	/Specify Yes or No	USA	1. Race - Amer	ncan Indian
)36 :: :: :: :: :: :: :: :: :: :: :: :: ::	il', or itan	by Fun	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fr	orces? 2 ∐ No ive		If Yes, specify Cut		? (Specify Yes or No uerto Rican, etc.)	1	Black, White Specify:Whi	e, etc.
Maryland 21215-0036	ital Hygiene. dothar than "natural", or Itams 23a or 28e-f showers. evant, the Medical Examination matter confined at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)	1-4or 5+)	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of	working	16b. Kind	d of Business/l	Industry
, L	Hygiene thar tha	Com	9th			Truc	k Drive					railer
aryland		To Be	17. Father's Name (First, Middle, La Louis Pappas					Shirl	Name (First, Middle ey Carso	on		
Mar	1 8 8 B		19a. Informant's Name/Relationshi Bonnie Pappas	o (Type, Print)					r Rural Route Numb • Balto			
nore, N	fitar r oth		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3		State	Place of Disp cemetery, cre	osition (Name of ematory or other pla	100)	Date	Gari	ation - City or 1	Town, State
Baltimore,			* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service U				n Fores	ess of Facility	05-05 Wesley (Chavi	st, M	FH
F			23a. Part Life the disease, or shock, or heart failure. List of	omplications that nly one cause on	caused the deleach line.	ath. Do not er	nter the mode of dy	ing, such as care	ve. Balt diac or respiratory a	rrest,	ID 212	Approximate Interval Between
	hysícian /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	ARGI	E C6	al l	らろで	CANCE	1		Onset and Death
	xaminer			Due to	(or as a conse	equence of): AST	ASIS	To	CANCET BRA1	N		
) poli	d dansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	equence of):						
. Box 68760, \	ohysician and the burial-transit	dical Exa	resulting in death) Last	Due to	(or as a conse	equence of):						
89	ng phy	Medic	IF FEMALE:									
O. Box	by the attending prize as	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live	itcome of preg birth 2 ☐ Fe nant at time of nown	tal death 3	☐Ectopic pregnand ☐ Other (specify)	зу		23	ld. Date of deli Month	very Day Year
S, P	signed by	ру Р	Part II. Other significant condition	s contributing to c	death but not re	sulting in the	undertying cause g	ven in Part I.	23e. Did t			the cause of death?
ecord	been signature	ompieted	(161					-	24a. Was			topsy findings available
		Comp		-					— auto		prior to o death?	ompletion of cause of 2 No
Vital	certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 1	ER/Outpatie	257.004 00	hor	Death (Check only o			~ .
on of	After this	Η,	27. Manner of Death Natural 5 Pending	28a. Date (Mor		28b. Time Injury	of 28c. Inju	4 🗆 (40/5)//	ng Home 5 ☐ Resi 28d. Describe			ilty)
Division of Vita	within 24 hours after death. To the Funancial Director: After completely filled in by the funer.	Certification:	2 Accident investigated investi	ot be 28e. Place	e of Injury - At ling, etc. (Spec	home, farm, s	treet, factory, office	103 20.10	28f. Location (City or To		Number or Ru	ral Route Number,
1	24 hours Funaral	edical C	29a. Certifier (Check only one) Certifying 2 Medical E	xaminer: On the b	e best of my ki basis of examin	nowledge, dea nation and/or i	ith occurred at the t nvestigation, in my	ime, date and pl opinion, death o	lace, and due to the occurred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
,	within To the	Me	29b. Signature and title of certifier	otak	Clan	i Wo	29c. Licen	se number 1802	5	29d. Date	signed (Month	, Day, Year)
	141		30. Name and address of person w		se of de th (Ite), Print) 224 (Co Ar	e n	AUTS. A	ND21237
• €	Sta Registr		31. Date filed (Month, Day, Year)	7	egistrar's Sign	-	parti	00-31	<u> </u>	٠, ، ،	0 11	, , , , ,

DHMH 17 Rev 1/2001

Registrar

MAY 0 4 2005

			For State Registrar		State of	Marylan	d / Depa		t of H	ealth a		ental Hy		_	15068
	Physici	an	1. Decedent's Name (Fi			-						2. Date of De.		Year	3. Time of Death
	/Medi		Michele		Raymond	Popka		T				April		2005 ^{Year}	
	Examir	ner	4a. Facility Name (If not			nber)				Location of				County of Dea	
			13212 Glet 5. Social Security Numb			7. Age (In yrs. I	ast hirthday)	If Under		Spri1	-	8 Date of Bird	1	Iontgo	mery nthplace (State or Foreign
	Funeral Director		537-52-63	30	1□M 21₹F	52	Yrs.	Months	Days	Hours	Min.	8. Date of Birt July 6	, Year 195	52 u	nknown
	yland now			b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	e-fst	ctor	MD	Mor	ntgomery	S	ilver	Sprin	ng						1 ☐XYes 2 ☐ No
	h with the 23a or 28 at be no	Funeral Director	10e. Street and Number 13212 Glen		Road			10f. Zip	Code 2090)4				en of What C	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28e-f show any Injury or other traumatic event, the Medical Examinar rulative rigitled at once.	by Funer	11. Marital Status 1 Never Married 3 Widowed 4		Armed For	² ₹No		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe ı, Puerto I	ecify Yes or No Rican, etc.)		4. Race - Am Black, Wh Specify:	erican Indian, ite, etc. white
21215-0036	vithin 72 ho ne. han "natur e Medical l	Completed by	(Specify of Elementary/Secondar		Education grade completed)	-4or 5+)	(Give life.	dent's Usua kind of wo DO NOT us Publis	rk done a se retired,	ntion Juring most)	t of workii	ng		d of Business	-
land 2	ld be filed v ental Hygie ked other t Ic event, th	To Be Co	17. Father's Name (Firs		ast)	}		UDITS	siter		_	(First, Middle,	Maiden S	Sumame)	
2	nd 2 shou lith and M 27 is mar	-	19a. Informant's Name. Bruce Pop					-				/Route Numbe Silver			Zip Code) 20904
Baltimore,	Pages 1 arent of Healent of Healent If item		20a. Method of Disposit 1 ☐ Burial 2 ☐ Ci 4 ☐ Donation 5 ☐	remation :	3 □Removal from Secify)	orgree	lace of Disponentery, cres			1 1	5/2/0	oste OS		ation · City o	r Town, State
Balti	permit. Departm Importe any Inju		21. Signature of Funera	al Sarvicar Li	cansae many	M0038Z	Ra Q	Name and App Fu	d Addres inera st Av	s of Facilit al and renue	Silv	emation ver Spr	ing.	rices MD 20	910 Approximate
	Physician /Medical		23a. Part1. Enter the d shock, or heart fai tmmediate Cause (Fina disease or condition resulting in death)		a. Bre	ast Can or as a consequ	cer	er the mod	e or dying	y, such as	cardiac o	1 165pilatory at			Interval Between Onset and Death
	Examiner	ner	Sequentially list condition if any, leading to immercause. Enter Underlyin Cause (Disease or injurthat initiated events	ons, diate	b	or as a consequ						· · · · · · · · · · · · · · · · · ·			
,092	te be executed ysician and te burial-transit	cal Examiner	Cause (Disease or injur that initiated events resulting in death) Last	, i	cDue to (or as a consequ	sence of):								
687	physicate by the b	edlo		`	d										
Box	The law requires that the death certificate be executed title has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 ☑ No 9 □ Unknown	nths?		irth 2 ☐ Fetal ant at time of de	death 3	⊒Ectopic pr] Other (sp					23	d. Date of de Month	elivery Day Year
rds, P.O.	quires that I in signed by uld be deta	by	Part II. Other significar	nt condition	s contributing to de	ath but not resu	ulting in the u	nderlying c	ause give	en in Part I.					o the cause of death?
I Records,		Completed									-	24a. Was autop perfo 1 \(\subseteq \text{ Yes} \)	rmed?	prior to death?	utopsy findings available completion of cause of
Vital	Physiclen: r this certificated director,	Be	25. Was case referred examiner?	to medical	1 la seisele				0.1			(Check only o			
of	this o	2	1 ☐ Yes 2 XX			npatient 2						ne 5X Resid			ecify)
ion	Attending F r death. ector: After by the funer	atlon	2 Accident	☐ Pending investiga	ition	h, Day Year)	28b. Time o Injury	M M	8c. Injury Work 1 🔲 \	at :? ∕es 2⊡I		28d. Describe h	now injury	occurred	
Division	itel or Atters as after de al Directo	Certification;	3 Suicide 6 4 Homicide	Could no determin	286. Place	of Injury · At ho ng, etc. <i>(Specif</i> y	me, farm, st	reet, factory	, office		2	28f. Location (5 City or Tow		Number or F	lural Route Number,
	To the Hospital or Attending Physiclen: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 one)	Medical E	Physician: To the xeminer: On the ba and mann	isis of examinat	wledge, deat ion and/or in	vestigation,	in my op	inion, dea	d place, a th occurre	ed at the time,	date and p	lace, and du	e to the cause(s)
	To I com	7	29b. Signature and title	of certifier	d 00	Q			. License	number	5			signed (Mon	th, Day, Year)
1	10		30. Name and address Dr. Che		ho co pleted cause lesworth,			Print)				er Spri	-		904
	Sta Flagist		31. Date filed (Month, E		7 0 4 200b	egistrar a signar	ture	So	and when	j'			SIL	Oll Vierni	

Physicia	an	For Amend Item 1 Registrar Unpend Item 1. Decedent's Name (First, Middle, La		.28a-f pe€€	rtificate of		2. Date of Death		3. Time of Deat
/Medic		Thomas Edward Per						2005	6:30 P
Examin	er	4a. Facility Name (If not institution, given 3437 KESWICK RD	re street and number			ORE CITY		4c. County of Dea	ath
Funeral Director		217-84-4983	Sex 7. A	ge (In yrs. last birthday 33 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 01/27/19		rthplace (State or Ford ountry)
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Lin
the Marylan 28a-f show	ţō	MD Baltimo	re City	Baltimor	3				1XYes 2
ith the or 28a e noti	Director	10e. Street and Number	ic city	Bartimor	10f. Zip Code		10g. (Citizen of What C	ountry?
23a o	a D	3437 Keswick Road			21211		Un	ited Sta	tes
after dea or Items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give	TN0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whi	te, etc.
72 hours natural', ilgal En	edt	15. Decedent's E	Year or Dates		dent's Usual Occup	ation	16h	Kind of Business	
d within 72 piene. r than "na	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-40)	(Give	kind of work done DO NOT use retired	during most of working d)	g	nstructi	•
e filed at Hygie I other vent, I	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	en Sumame)	
2 should be to and Mental His marked of raumatic aver	To B	Ronald Wayne Mear	s			Barbara	Ruth		
and Name		19a. Informant's Name/Relationship (Туре, Print)	19b. Mail	ng Address (Street	and Number or Rural	Route Number, City	y or Town, State,	Zip Code)
and 2 salth n 27 I		Barbara Mears/Mot	her			Road Balti	more, MD	21211	
permit. Pages 1 and 2 Department of Health a Important: If fem 27 is any injury or other tra	3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	Da	1 200.	Location - City or	Town, State
Pag ment ant: I		* 4 □ Donation 5 □ Other (Special			ke Cremat	ory Inc. 2	pr 29 005 Bei	ltsville,	Maryland
permit. Depart Import any inj once.	li i	21. Signature of Funeral Service Lice	nsee /		2. Name and Addre	ss of Facility and Funeral	71+	·	
₹0 ≥ € Ø		23a. Part1. Enter the disease, or com shock, or heart failure. List only			717 Green	Pastures D	rive Bali		aryland 21
ficate be executed by physician and stree burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence of): s a consequence of):					
eath certif attending for use as	Physiclan/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of de Month	livery Day Year
w requires that the de been signed by the should be detached	b	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.			o the cause of death
ician: The law r. certificate has be rector, page 2 sh	Be Completed	25. Was case referred to medical				26. Place of Death (24a. Was an autopsy performed?	prior to death?	utopsy findings avail completion of cause 2 No
Physici, this cer al direc	To B	eraminer? 1∰ Yes 2 □ No	Hospital: 1 Inpat	ient 2 ☐ ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing Home	e 5 Residence	6X Other (Spe	ocity) SCENE
Attending Physician: r death. sctor: After this certifice by the funeral director, I	Certification: 7	27. Manner of Death 1 Natural 5 Pending investigatio		ay Year) 28b. Time o	Worl	yat 28 k? Yes 2 X No	d. Describe how inj	jury occurred	unk
br At fter d lirect n by l	Sertiff	3 ☐ Suicide 6 X Could not be determined	200. Flace UI II	njury - At home, farm, st etc. (Specify)	reet, factory, office	Per Per	of Location (Street a City or Town, Sta Ltimore,	and Number of Bo te) 3437 Ko MD	ural Route Number e swick Rd
ral D			vsician: To the bes	t of my knowledge, deat	h occurred at the tin	ne, date and place, an	d due to the cause((s) and manner as	s stated.
the Hospital hin 24 hours a the Funeral D npletely filled i		(Check only one) 2X Medical Example one)	niner: On the basis and manner s	of examination and/or in tated.					
within 24 hours after death. To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	Medical	(Check_only 2X Medical Exa	niner: On the basis and manner s	of examination and/or in tated.	29c. Licenso		29d. D	Pate signed (Mont	h, Day, Year)

			For State Registrar	State of	Maryland / D		rtment <i>tificate</i>			and M	lental Hy	giene Reg. No.	005	15070
	Discontinu		1. Decedent's Name (First, Middle, Last)								2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Joanne Peters	heim							April		005	2:20 p M
	Examir		4a. Facility Name (If not institution, give s		er)		4b. City, T	Town, or	Location of	of Death		4c. C	ounty of Dea	ath
			Mariner Health C						gton				lontgo	
	Funeral Director		213-40-0362	M 2 X F	Age (In yrs. last birt	rhday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Oct • 7	th 19, Year) 194	C	rthplace (State or Foreign country) Ssachusetts
	and		Usuel Residence of Decedent 10a, State 10b, County		10c. City, Town	or Lo	cation							10d. Inside City Limits
	/anyl	៦	MD Montgo	me r v			Park							1X Yes 2 □ No
	28a-	ect	10e. Street and Number	ист у	Tak	Ullia	101. Žip (10a Citize	n of What C	ountry?
	with Se or	0	7425 Piney Branch	Road				2091	2				ed Sta	
	ns 23	era		12. Was Decede	ent Ever in U.S.	13. V				gin? (Spe	ecify Yes or No			erican Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland Jione. I then "natural", or Items 23e or 28e-f ehow The Madisal Ezamir at must be notified at	by Funeral Director	1 □ Never Married 2 □ Married 3 □ Widowed 4 ② Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	\$\$? ∑ No		Yes, speci			ĭ, Puèrto	ecify Yes or No Rican, etc.)		Black, Whi	
ŏ	2 hot	ted	15. Decedent's Edu		16a.	Deced	ent's Usual	Occupa	tion			16b. Kind	l of Business	s/Industry
215	within 72 ene. then "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	life. [kind of worl OO NOT use	e retired)	u <i>ring</i> mos	t of work	ing	_		
21	e filed within al Hygiene. I other then ' vent, the we	no.	12			Sec:	retar	У				Fe	deral	Government
b	be filed stal Hygid stal other event, I	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	e (First, Middle	, Maiden Si	umame)	
/la	should be nd Mental marked o umatic eve	2	Stephen R. Conno	1 1y					Lot	ise	Agnes	Conno	11y	
ar	es 1 and 2 should bot Health and Ment Item 27 is marked r other treumatic e	9 1	19a. Informant's Name/Relationship (Ty) Chris Petersheir								al Route Numb	-		
	and fealth m 27 her tu			.11/ 5011					ancn		d, Tako			
Baltimore,	Pages 1 ent of H nt: If Ite ry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from St	20b. Place of cemeter, Chesar	y, cren	atory or otl	h er place			2, 200			Town, State
Balti	permit. Pages 'Department of H importent: If Ite any injury or ot once.		21. Signature of Funeral Service License	99	M00382	Ra	Name and	ıner.	s of Facilit	id Cı	remation	n Ser	vićes	
			23a. Part1. Enter the disease, or compli	cations that cau	sed the death. Do n						_		MD 2	.0910 Approximate
			shock, or heart failure. List only or Immediate Cause (Final					D 1						Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	• —	ronic Obst		ctive	Puli	nonar	у Бі	Isease			
	Examiner			,	43 4 0011304001100 0	,,,								
		je	Sequentially list conditions, if any, leading to immediate causs. Enter Undertying Cause (Disease or injury		as a consequence of	of):								
	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events											
ó	an ar	EX	resulting in death) Last	Due to (or	as a consequence of	of):								
8760,	cate be executed bhysician and the burial-transit	dical												
39	intification of a section of the sec	Med	IF FEMALE:											
Вох	death certific e attending p ad for use as	an/l	23b. Was decedent pregnant in the past 12 months?		me of pregnancy ∩ 2 ☐ Fetal death	3 □	Ectopic pre	gnancy				230	d. Date of de Month	livery Day Year
0	the a	Physician/Me	1 ☐ Yes 2X No 9 ☐ Unknown	4∐Pregnar 9□ Unknow	it at time of death n	5 🗌	Other (spe	cify)						ouy rour
P.(that the de led by the a detached t		Part II. Other significant conditions con	tributing to dea	th but not resulting in	the un	iderlying ca	use dive	n in Part I		23e Did t	obacco use	contribute t	o the cause of death?
Records,	sign d be	ed by										Yes 2□		robably 4 Dunknown
DCC	law requas been 2 shoul	Completed									24a. Was		24b. Were a	utopsy findings available completion of cause of
Ä	The tate has page	E O									perfo	rmed? 2 ANo	death?	s 2 No
Vital	ian: The	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
of <	Physician: this certific ral director,	2	1 Yes 2 No	ospital: 1 🗆 Inp	atient 2 ER/Out	patient	3 DO	Othe	r: 4 X Nu	rsing Ho	me 5 🗆 Resi	dence 6 [Other (Spe	ecify)
0			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. T Day Year) Ir	ime of njury	28	lc. Injury Work	at ?		28d. Describe	how injury o	occurred	
Sio	Attending r death. sctor: After oy the funer	cati	2 Accident investigation				М	1 🗆 Y	es 2 🗌	No				
Division	or Attendater death Director: in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At home, far , etc. <i>(Specify)</i>	m, stre	et, factory,	office			28f. Location (. City or To		Vumber or R	ural Route Number,
	Hospital 4 hours Funeral ely filled	edical Co	29a. Certifier 1 X Certifying Phys (Check only one) 2 Medical Exemin	ner: On the bas	s of examination and	, death	occurred a estigation, i	t the time	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) ar date and pl	nd manner a ace, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of pertifier	and manne	stateu.		29c.	License	number			29d, Date s	signed (Mon	th, Day, Year)
	F3F8								3962				2, 20	
1	1		20 Name and address of access of	mploted sauce	of death (line: 00-10	Tues '	Print'							
L			30. Name and address of person who co Dr. Shashank Pat				ald Ro	nad.	Whee	ton	MD 20	902		
	Sta	te							ca	.20119		,,02		
	Registr		31. Date filed (Month, Day, Year) 0 4	2005	isfar's Signature	-	3	C. C.						

ROEMER, CATHERINE Baltimore, Maryland 21215-0036

Box 68760,	
P.O.	
Records,	
of Vital	
Division (

		Please Type o State State Registrar		d / Depa		lealth and M	•		Legible.	15071
Physicia		1. Decedent's Name (First, Middle, Last) Catherine I. Roemer					2. Date of De Month		Year 2005	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and STNAT HOSP)	number)		4b. City, Town, o	Location of Death			County of Deat	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ey. 1911	9 Rin	hplace (State or Foreign
ehow	or.	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. Cit	y, Town or Lo Balt	ocation cimore		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits 1 ☐ Yes 2 🕅 No
with the M 3a or 28a-f	Direct	10e. Street and Number 6204 Smith Avenue	,	-	10f. Zip Code 21209			10g. Citiz	zen of What Co	
2 should be filled within 72 hours after death with the Maryland and Mantal Hygiene. ie markad other then "naturel", or items 23a or 28s-f ehow reumatic event, it e Marical Exs. It er mark to notified at	by Funeral Director	11. Marital Status 12. Was D Armed 1 Never Married 2 Married 1 \ Yes.	ecedent Ever in U Forces? s 2)(No Give Dates:		Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0~ 1	4. Race - Ame Black, Whit Specify: Whi	e, etc.
vithin 72 houne.	Be Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) o (1-4or 5+)	16a. Dece (Give life. Homemal		ation during most of work d)	ing		nd of Business	Industry
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If tiem 27 ie markad other then "naturef, , eny injury or other treumatic event, II e M. Jic. I Eve once.	To Be Co	17. Father's Name (First, Middle, Last) Harry Hecker		Tonena		18. Mother's Name		1	Sumame)	
and 2 shot ealth and M m 27 ie ma		19a. Informant's Name/Relationship (Type, Print) William J. Roemer/Son		6204	Smith Aven		al Route Numb re Maryla	-	Town, State, 2 1209	Zip Code)
Pages 1 iment of He tent: If iten		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal fro 14 □ Donation 5 □ Other (Specify)	m State Gar	Place of Dispo cemetery, crei dens of	osition (Name of matory or other place Faith	5/4,	Oate / 05		imore Mai	
permit. Departimport Import eny inj		21. Signature of Funeral Service Licensee Chri Christian & Hel	stina L. H tow		2. Name and Addre Leonard J. 1 5305 Harford	ss of Facility Ruck Inc . d Road Ba1	timore Ma	arvlan	d 21214	
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) a	t caused the deat n each line. Y O C A f (or as a conseq	2diA	ter the mode of dyin	g, such as cardiac o		arrest,		Approximate Interval Between Onset and Death
bul bul	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a conseq							
to the Hospitel or Attending Physicien: The law requires that the death certificate I within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total or the funeral director.	by Physician/Medic	in the past 12 months?	outcome of pregna e birth 2 Feta egnant at time of d known	il death 3	□Ectopic pregnancy □ Other (specify)	,		2	3d. Date of del Month	ivery Day Year
quires that the dean signad by the a		Part II. Other significant conditions contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.			se contribute to ∃No 3 □ Pr	the cause of death?
: The law require cate has been sion page 2 should to	Completed						24a. Was auto perfo 1 - Yes		24b. Were au prior to death? 1 Yes	topsy findings available completion of cause of
sician s certifi irector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	☐ Inpatient 2	ER/Outpatier	nt 3 DOA Oth	26. Place of Deather: 4 □ Nursing Ho			Other (Spe	~/h/)
nding Ph) uth. r: After this e funeral c	ation: T	27. Manner of Death 28a. Da	te of Injury onth, Day Year)	28b. Time of Injury	f 28c. Injun Wor		28d. Describe			ary)
To tha Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ice of Injury - At he ilding, etc. (Specif	ome, farm, str	reet, factory, office			Street and wn, State)	Number or Ru	ral Route Number,
ha Hospil in 24 hour he Funer pletely filli	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and m	the best of my kno basis of examina anner stated.	owledge, death	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
To To To Com	2	,29b. Signature and title of partifier Physi	ciAN		29c. Licenso		8		signed (Month	
10"		30. Name and address of person who completed co	JR,M	02	Print)	Belveder	ReAve	BA	1+imor	2, 2005 Reimo 2121S
Stat		31. Date filed (Month, Day, Year) MAY 0 4 2005	. Registrar's Signa	ature	160					

			1- State of Mai		artment <i>rtificate</i>			ind Me		iene) (15	15072	
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death	of Death 3. Time of Death				
	Physici /Medic		Henrietta J. Rudacill	9					May	3	2005	0345 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospi	4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery			У		
	Funeral Director		214-40-5236 ^{1□M 2⊠F}	(In yrs. last birthday) 96 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. Ma. (M. A.)				Date of Birth Month, Day, March 1.	ate of Birth Month, Day, Year) rch 12, 1909 Birthplace (State or Foreign Maryland			
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Medical Exameter I was been will be a diffied at	tor	Usual Residence of Decedent 10a. State 10b. County	Oc. City, Town or Lo	ocation						1	0d. Inside City Limits	
											1 ☐ Yes 2 🛣 No		
		Director	10e. Street and Number				10f. Zip Code 10g.					itry?	
			301 Russell Ave.	20877 U					United	Stat	es		
36		To Be Completed by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 1 ☐ Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ Nor If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2돐 No Specify:					Bla	14. Race - American Indian, Black, White, etc. Specify: White			
9			15. Decedent's Education 16a. Dec			edent's Usual Occupation 16					b. Kind of Business/Industry		
215			(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during m				uring most	of working					
7			5+ School Teacher						Baltimore City School				
nd			17. Father's Name (First, Middle, Last)	Pudaoi 11.	0				First, Middle, M Brook M		,		
Maryland 21215-0036			Granville Kesselring Rudacille Nellie Brook Whittington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Z Z			Thomas Bradford Cousin		87 Ed					bine,		1797	
ē,	s 1 ar if Hea item other		20a. Method of Disposition	20b. Place of Dispo cemetery, crei	sition (Name	e of	1	Dat	e 2	Oc. Location	- City or To	wn, State	
altimore,	Page nent o int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Parkwood		•	·	ay 5,	2005 I	Baltimo	ore, l	MD CITY	
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once.		21. Signature of Funeral Service Licensee		Name and Burrie 1212 W				al Home Road	& Cre Winfie	mator	y, PA D 21784	
	Physician floating and floating		23a / art1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between										
			Onset and Death disease or condition								Onset and Death		
		<u>.</u>	resulting in death) Due to (or as a	con equence of):				-					
			Sequentially list conditions, if any, leading to immediate										
		Examiner	cause. Enter Underlying Cause (Disease or injury										
Ć,			talled the state of the state o	consequence of):									
8760,	te be ysicia ne bur	dical	d										
9	ntifica ng ph	0 1	IF FEMALE:			_							
Box	ysician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	lan/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unkn						230		d. Date of delivery Month Day Year		
0		Physician/M										7001	
Δ.		/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?			e cause of death?	
rds,		d by	Right hip fracture						1 ☐ Yes	2 No	2 No 3 Probably 4 □Unknown		
Record		Completed							24a. Was an			osy findings available	
		mo							autopsy perform 1 Yes 2	ed?	prior to completion of cause of death?		
Vital		BeC	25. Was case referred to medical 26. Place of Death (Check only one)										
<u>></u>	Physic this ceral dire	To	examiner? Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
Division of	ing P	iuo!	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?										
S	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	icat	2) Accident investigation 4 2 1 1 5 un know im 1 Yes 2 No 1 21 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1										
<u>></u>		Certification:	4 Homicide						City or Town, State) 30/ RUSSE// HVE.				
	spite hours ineral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as tieted.										
	he Ho in 24 i he Fu pletel	Medical	(Check only 2 Medical Examiner: On the basis of each manner state	kamination and/or in u.	vestigation, in	n my opi	nion, death	n occurred	at the time, dat	te and place,	and due to	the cause(s)	
	with To 1	3	29b. Signature and title of certifier	Ma. hu	29c.	License	number 5/9//	0	29	d. Date signe	d (Month, L	Day, Year)	
	//		Patticia Jomska	jung, MK		ν	11/1/	7	/	riay	0) 2		
16)		30 Name and address of person who completed cause of dea	110 ROD	Luille	b	Lo	C-11	50 D.	Lui	1/6 1	MD 20852	
-	Sta	ta.	31. Date filed (Month, Day, Year) 32. Aegistran	mature 1	VIIIE	1/1	15	0 10	4 100	- NV//	10,11	111 20002	
	Registr	-	MAY 0 4 2005	signature L	4 40	BALL							

			ar	mend item #8&20b PR	State of Ma R FH G843	aryland / D 5/04/0!	epa Co F	rtment of F <i>lificate of</i> a	lealth and N Death		giene Reg. No 2 ()	The state of the s	15070
		Physic		Decedent's Name (First, Middle, Les STEPHEN	C			RIFKI	ND	2. Date of Dea Month	S.Com	Year 2005	3. Time of Death
		/Medi Examir		4a. Facility Name (If not institution, give	street end number)	wre			BALTIMUY	ocetion of Death			10.11.11
		Funeral Director		5. Social Security Number 6. Se 215–25–5414	7. Age	e (In yrs. last birti	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1985		ece (State or Foreign
				Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation					Od. Inside City Limits
		death with the Meryland ms 23a or 28a-f ehow r must be notilised at	Director	MD BALTIM	ORE	OWIN	IGS	MILLS					1 □ Yes 2 X No
		3a or	Ö	12096 LONG LAKE D	RIVE			10f. Zip Code 21117			10g. Citizen of U.S./		ry?
HAN	020	72 hours after deat natural', or items 2 dical Examiner my	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N N If Yes, Give Year or Dates:	Ever in U,S.		1	ispenic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Specil	ce - America ck, White, e y: BLA	etc.
STEPHEN	21215-0020	c • 6	Completed	15. Decedent's Edi (Specify only highest gred Elementary/Secondary (0-12)	location (e completed) College (1-4or 5-	+)	Decede (Give k life. D	ent's Usual Occup ind of work done o O NOT use retired	ation during most of work ()	ing	16b. Kind of B		ustry
N/	Baltimore, Maryland	e d is b	To Be C	17. Father's Name (First, Middle, Last) MICHAEL			RIF	KIND	18. Mother's Name SUSANNE	e (First, Middle,	Maiden Surnar		BERT
RIFIKIND	Man	nd 2 lith c	0 8	19a. Informant's Name/Relationship (T) MICHAEL RIFKIND					and Number or Run KE DRIVE		r, City or Town		
-	more	Pages 1 a ent of Hes nt: If Item ry or othe		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of cemetery BETH J	, crem	atory or other plac	e) <u>85</u> /	Date 02/2005	20c. Location FINKS	-	vn, State
	Balti	permit. Pages Depertment of Important: If it eny injury or o		21. Signature of Funeral Service Licens		<u> </u>	22.	Name and Addres	ss of Facility SOL	LEVINS	SON & BI	ROS.,	INC.
	0	Physician		23a. Part1. Enter the disease, or comp shock, or heert failure. List only o	ications that caused ne cause on each line	the death. Do no	ot ente	the mode of dyin	g, such as cardiac o	or respiretory ar	rest,	-	Approximate Interval Between Onset and Death
		/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	ROPTO							HOURS
1	X)	uted	Examiner	Sequentially list conditions	. AURTIC	Due to (or es e co DISSEC Due to (or es e co	TION	٠, .				1	8 Hours
4	68760,	icete be executed physician end s the burial-transit	edical Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	MARFAI		DR	OME				Si	NCE BIRTH
	Box 68			resulting in death) Last	d	one to (or as a co	onseque	ence orj.					
	Ö.	e death the atte	Physician/M	Part II. Other eignificant conditions cor	ntributing to death but	t not resulting in	the unc	lerlying cause give	en in Part I.	23b. Did to	bacco use co	ntribute to	the ceuse of deeth?
	s, P.(v requires that the death certif been signed by the attending should be deteched for use e	by Phy							1 🗆 Y	es 2□No	3 ⊠ Prob	ably 4 ☐ Unknown
	ecord	lew requires test that the second sec	Completed					P. Sp. Servadary		24e. Wes a perfor	n autopsy med?	evai	e eutopsy findings leble prior to pletion of cause eath?
	a R	t: The icate h r, page									es 2₺No	10	Yes 2 No
	f Vit	Physician: this certific ral director,	To Be	25. Wes case referred to medical examiner? 1 1 Yes 2 No	lospitel:	nt 2 ☐ ER/Outp	patient	3□ DOA Othe	26. Place of Deeth or: 4□ Nursing Hor			er (Specify)	
	o uc	ding Ph h. After th funeral	tion:	27. Manner of Death 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	28b. Tir		28c. Injury Work		28d. Describe h			
	$\overline{}$	To the Hospital or Attending Physician: The lew within 24 Hours effer death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farn (Specify)	m, stree			28f. Location (Si City or Town		er or Rurel	Route Number,
		To the Hospital within 24 hours of To the Funerel completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemin	sician: To the best of ner: On the basis of e and manner state	examination end/	deeth o	occurred at the tim stigation, in my op	e, date end place, a inion, death occurre	and due to the co	ause(s) end ma ate and place,	nner as sta and due to t	ted. he cause(s)
		Vithin To th	Me	29b. Signature and title of certifier		C 24-		29c. License		2	9d. Date signe	d (Month, D	ey, Yeer)
1		1		Peour W. Ch				D41	129		APRIL 2	9,200	5
		2		PETGL W. CHO, MD	2435 W. B	ervedere	AVI		35 BALTIN	YORE, MI	21215		
		Sta Registra		31. Date filed (Month, Day, Yeer)	32. Registrar	's Signature	W						

DHMH 16 Rev 6/95

		•	1 - For State Registrar	State of Mary		artment of H			ene 3. No.2 0 0 5	15074
	Dhysisi	an	1. Decedent's Name (First, Middle,					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio			Anna	Robb				130, 2005	5:15 p M
1	Examir	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Deat	th	4c. County of De	ath
				omery General Hos	pital n yrs. last birthday	If Under 1 Year	If Under 24 Hrs	Olney		ontgomery
	Funeral Director		215.36.4726	1□ M 200 F	94 Yrs.	Months Days	Hours Min.		(ear)	irthplace (State or Foreign Country)
			Usual Residence of Decedent		О Т		1	September 1	5, 1910 ¹	Connecticutt
	show	L	10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	8a-f s	cto	Maryland Monto	omery			ver Spring			1 □ Yes 2 No
	with th	D E	10e. Street and Number			10f. Zip Code		100	g. Citizen of What (•
	s 23e	Funeral Director	14124 Heritage Lane	12. Was Decedent Eve	r in 11 C 12	Man Decedest of U	20906	Specific Ven au Na	14. Race - An	I.S.A.
	ter de	Ľ,	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	111 0.3.	Was Decedent of H If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, Wh	
936	urs af	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
Maryland 21215-0036	in 72 hours after death with the Maryland 1 "natural", or Itams 23a or 28a-f show Isolical Examiner must be multired at	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa	ation	rking 16	3b. Kind of Busines	s/Industry
21	S - 2	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	i)	rking	at	t home
21	77 75 1		12			hor	nemaker			
and	d o d	Be	17. Father's Name (First, Middle, La				18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
ž	should nd Mer marke umaric	2	Jared 19a. Informant's Name/Relationship	Alton Loomis	10h Maili	an Address (Strant	and Alumbas as O		ra_Eaton	7:- 0- 4-1
Ma	12 7 18							ural Route Number, (ZIP Code)
	Hea Hea tha	1 3	Mr. Richard A. Rob 20a. Method of Disposition		20b. Place of Disp	osition (Name of		er Spring, Man Date 20	land 20906 c. Location - City of	r Town, State
ē	0 0		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemetery, cre	matory or other plac	1	10010005		
altimore,			21. Signature of Funegal Service Lie		E:	ast Cemetery 2. Name and Add es		5/06/2005	Mancr	nester, CT
ä	permit. Departr Importa any inji		23a/Part1. Enter the disease, or co	The Mas.	53	Slack F	uneral Hom	ie, P.A.		
8760,	Amedical Examiner with a prize be executed whysician and the burial-transit the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or as a co	onsequence of):					Onset and Death
O. Box 6	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy			23d. Date of di Month	elivery Day Year
rds, P	slgr slgr d be	by	Part II. Dther significant condition	s contributing to death but not they DISENSE Leaf 141 Ac		, ,	en in Part I.	23e. Did toba 1 ☐ Yes		to the cause of death? Probably 4 □Unknown
Vital Records,	The ate h page	Completed	Cerebro VAS	delan Ac	(1000)	-		24a. Was an autopsy performe	prior to	
/ita	clan: ector,	Be	25. Was case referred to medical examiner?	Hamisel				ath (Check only one)		
of	Physi this o	은	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie		4 Indising i	lome 5 Resident		ecify)
ח	ing After une	lon	27. Manufer of Death Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Work		28d. Describe how	injury occurred	
isi	att att	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be	At home farm et		Yes 2 □ No	28f Location (Stre	et and Number or F	Rural Route Number,
Division	or Attand after death Director:	Certification:	4 ☐ Homicide determin	building, etc. (S		reet, ractory, office		City or Town,	State)	nural moute muniber,
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of mainer: On the basis of examiner: and manner stated	amination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner a a and place, and du	as stated. le to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. License	number	290	. Date signed (Mor	oth, Day, Year)
	N		> 4 Sola	- 40		N83	+26	M	Ay 1 2	005
1	5			no completed cause of death	(Item 23a) (Type	Print) P.	awa Ph.	his Dr. OL	NES M	1 20832
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Soule		1. Dr. 04.		

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryl		artment of Hertificate of E				
	Physici	an	Decedent's Name (First, Middle, Last,	C .		undate of E		2. Date of Death	Day Yeer	3 Time of Death 5
	/Media	cal	Robert J. 4a. Facility Name (If not institution, give	Jander,	1	4b. City, Town, or	Location of Dooth	April	30 200 4c. County of Dea	7 7 13
	Examir	ıer	Johns Hopkins Bay		1 Center	Baltin				1(1)
	Funeral		5. Social Security Number 6. Sec	7. Age (In)	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	N/A 9. Bi	rthplace (State or Foreign ountry)
11	Director		219-90-9121 14	M 2□F	12 Yrs.	Months Days	Hours Min.	Month, Day,	-01010	rvland
	D >		Usuel Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo					10d. Inside City Limits
	show	ō	Tob. County	100.	oky, town or Lo	Cation				1 Yes 2 No
	the N	Director	Maryland Bal 10e. Street and Number	timore		10f. Zip Code	Dund		g. Citizen of What C	
	3e or		1926 Frames Road			10.1. E.P 0000	21222	"		•
	death ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever i		Was Decedent of His	panic Origin? (Sp	pecify Yes or No-	United S	erican Indian,
36	be filed within 72 hours after death with the Maryland that Hygiene. Idea dy service then "naturel", or items 23e or 28e-f show event, the Mexical Exercil er confit of an event, the Mexical Exercil er confit of an event.	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cubar 1 □ Yes 2 🙀 No	Specify:	o Rican, etc.)	Black, Wh	_{ite, etc.} White
21215-0036	2 hou		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupat	tion	1	6b. Kind of Business	s/Industry
215	- 4	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done du DO NOT use retired)	iring most or won	King		
	filed with Hygien the the the the	Cor	10 Years		True	ck Driver			Trucking	
and	S should be filed within and Mental Hygiene. Ie marked other then eumatic event, The M	Be	17. Father's Name (First, Middle, Last)	-				ne (First, Middle, M	aiden Sumame)	
Maryland	should ind Man marke umatic	2	Robert J. Sande		10h Mailie	Address /Ctmsts	Sara		nsel City or Town, State,	7:- O- d- \
Ma	nd 2 s alth an 27 le i r treui		Mrs. Debora E. Sa		1.0	26 Frames		undalk, M		21222
ē,	the He		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	b. Place of Dispo	sition (Name of			0c. Location - City o	
Baltimore,			1 ☐ Burial 2 ☑ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		-	natory or other place Service Co		/2005	Towson,	Maruland
計	- F # #		21. Signature Funeral Service Licens	and the second s	22	. Name and Address	of Facility			
Ö	Departing any in once.		Fregn 2	100		ouda-Ruck 922 Wise			Dundalk, arvland	Inc. 21222
ı			23a. Part1. Enter the disease, or compleshock, or hear failure. List only or	cations that caused the die cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Liver o		*				5-10 Veavs
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					4
1	Examine	_	Sequentially list conditions,	Hepato	rena sequence of):	Syna	rone	•		LWEEKS
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	H antic	3 0 10	l Synd cephal	opath	7 J		IWEEK
Ć,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a con	sequence of):	ceprion	oporci.)		
68760,	ficate be executed physician and s the burial-transit	edical		1						
68	ntifica ng ph as th		(CCCMALC.							
Вох	ath cert attendin for use	Physician/M	230. Was decedent pregnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of de	
O. E.	at the dea by the at tached fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)			Month	Day Year
P.0	hat th ad by detacl		Part II. Other significant conditions cor	stributing to death but not	resulting in the u	nderlying cause giver	in Part I	23e Did toba	acco use contribute t	o the cause of death?
Vital Records,	quires thai n signed l	d by	Smoking	and any to doubt but not		Idenying cade given	THIT CITY.		2 □ No 3 □ P	
CO	sw require s been si	Completed						24a. Was an	24b. Were a	utopsy findings available
æ	The lavate has	E o						autopsy perform	prior to	completion of cause of
ita	sicien: certifica irector, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		-X
of V	hysic his ce I direc	To	1 ☐ Yes 2 No		2 ER/Outpatier	t 3□ DOA Other	4 🗌 Nursing Ho	ome 5 Resider	ce 6 □Other (Spe	ecify)
o uc	ding Ph h. After th funeral	inol	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time or Injury	Work?		28d. Describe hov	vinjury occurred	
Division	ar death rector: by the t	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home form etr		es 2□No	28f Location (Stre	et and Number or R	ural Route Number
<u>></u>	for A after Direction by	ertif	4 Homicide determined	building, etc. (Sp	ecify)	eet, ractory, onice		City or Town,		urai rioute ivamber,
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death	occurred at the time restigation, in my opi	, date and place, nion, death occur	and due to the cau	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	o the	Med	29b. Signature and title of certifier	and manner stated,		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	F ≤ F ŏ		1/10h	Roals	M.D.	RES	-000	A	2017.	2005
	11/9		30. Name and address of person who co					7 1	<u> </u>	
	101,		Ashley Bone H.), 4940 EO	stern	Evenue.	Baltim	ove, MD	21224	
	Sta		31. Date filed (Month, Day, Year)	32. A gistrar's Si	ignature	hart's		, , , , ,		
	Registi	ar	MAY 0 4 2	005 Medicine	15 /6)	AL PRIVATE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TO THE PERSON NAM				

DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of IVI	•	epartment of r Certificate of		-	gierie Reg. No. 2 ()	A5	15070
	Dhysisi	20	1. Decedent's Name (First, Middle, Las	it)				2. Dete of De Month	eth Day	Year	3. Time of Death
	Physicia /Medic		William	E	•	Shoebro		April	29 200)5	8:30pm
	Examin	er	4e Fecility Neme (If not institution, give	street and number)			4b. City, Town, or L		4c. County o	f Deeth	
			Keswick Nursing 5. Social Security Number 6. So		e (In yrs. lest birth	(a) If Under 1 Year	Baltimo	8. Date of Bir	th	O Diebel	and (Chata as Facility
	Funeral Director			M 2□ F	80 Yr	Months Days	Hours Min.	(Month, De	y, Yeer)		ace (State or Foreign try) ID
	land		10a. Stete 10b. County		10c. City, Town o	or Location				10	Od. Inside City Limits
	Mary First	to	MD NA		Balti	more					Y☐ Yes 2☐ No
	h the	Director	10e. Street end Number		Darde	10f. Zíp Code			10g. Citizen of Wi	nat Count	ry?
	15 wit	aiD	4797 1/2 Shamr	ock Ave		2120	06		U.S	3.A.	
	dea T	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of H If Yes, specify Cub		ecify Yes or No	- 14. Race	- America	
21215-0020	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "natural" or items 23a or 28a-f show ite Medical Examiner must be notified at	Completed by Fu	1 ☐ Never Married 2 ☐ Married	XXVes 2 ☐ I If Yes, Give Year or Dates:	No	1□Yes 20X No			Specify:		ack
5	72 h	etec	15. Decedent's Ed (Specify only highest gre-	ucation de completed)	16e. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	etion during most of work	ing	16b. Kind of Bus	iness/Ind	ustry
121	within ene. than	mp	Elementary/Secondary (0-12)	College (1-4or 5)+)				D		0
	e filed within ti Hygiene. other than vent, tre M	ပ္ပို	8th grade 17. Father's Name (First, Middle, Last)	na		roduction			Domino Maiden Sumame		ar Co.
a	d be ontai	Be c	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Unkno	√n	Ollie				•
Maryland	2 should be and Mentai a marked o	ို	19a. Informant's Name/Relationship (7	vpe, Print)	19b. N	Mailing Address (Street				tate, Zip	Code)
		Ì	Bernadette Wat								21206
ē,	of Haaith	1	20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other plan		Date	20c. Location - C		vn, State
Ë	Peges nent of nt: if ht iry or o		1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		•	nd_Nation		/5/05	Laurel	I . М	Б
Baltimore,	permit. Pege Department of Important: If any Injury or pnce.	1	21. Si mature of Funeral Service Licen	\$00		22. Name and Addre		7.57.55	Juure	-	-
<u>m</u>	Pen		tours +	t. Thum		4300 Waba		Balti	more, N	1d	21215
			23a. Pert1. Enter the diseese, or composhock or heart failure. List only	plications that caused one cause on each lin						1	Approximate Interval Between
	Physician /Medical Examiner	6	Immediate eause (Final disease or condition resulting in death)	a. Ne	Due to (or as a cor	A Back	lerial,	pneu	morria	1	onset and Death
		ner			D00 to (01 as a col	isequence ory.					
	tificate be axecuted g physician and as the burial-transit	Examiner	Sequentially list conditions,	b	Due to (or as a cor	nsequence of):					
Ő,	oe axe		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	C						100	
68760,	physic the t	edicai	that initieted events resulting in death) Last		Due to (or es e cor	sequence of):					
		Me		d							
Вох	eath cert attanding	ciar									
0	that the de led by the a detached	hys	Part II. Other significant conditions co	ntributing to death bi	it not resulting in tr	e underlying cause giv	en in Part I.	230. Dia 1	10	noute to 3 □ Prob	the cause of death?
٦,	es that igned b	Y P	CHNNU OBST	norwe (ungdi	SEAJE			ies Zalio .		ibiy 4 dikilowii
of Vital Records,	The lew requires that the death cer ite has been signed by the attandin page 2 should be detached for use	Completed by Physician/M	ischemic V	reart d	isease	<u>ب</u>			an autopsy rmed?	avai	re autopsy findings ilable prior to spletion of cause eath?
Re	The lew sate has page 2	d L	24051 (7.	: [] at	1/1			101	es zXivo		Yes 2□ No
ta	ician: The cartificate ractor, pag	BeC	25. Was case referred to medical	Victoria			26. Place of Deat		/		763 22.770
\leq		으	examiner? 1 ☐ Yes 2 (X) No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	atient 3 DOA Oth		7	lence 6 Other	(Specify))
0	ding Phys h. Aftar this funaral d		27. Menner of Deeth 1 ☑ Netural 5 ☐ Pending	28e. Dete of Injur (Month, De)	y 28b. Tim				ow injury occurred		
Sio	Attanding ar deeth. ector: Attar by the funa	catic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No				
Division	or Attandi aftar deeth. Director: A in by the fu	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm c. <i>(Specify)</i>	, street, factory, office		28f. Location (S City or Tox	Street and Number m, Stete)	or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircomplataly filled in		29a. Certifier NZ Certifying Phy	reicien: To the heet o	of my knowledge d	eath occurred at the tir	me date and place	and due to the	rause(s) and man	nor ac eta	ated
	To the Hospital within 24 hours a To the Funeral I complately filled	edicai			examination end/o	r investigation, in my o					
	within 2 To the compla	¥	29b. Signature end title of certifier	1	2	29c. Licens			29d. Date signed (
	ĺ		I M Chrish	my flet	y, u	10 Da	5205		MAY.	2,2	.005
/	24/1	7	30. Neme end address of person who o		1 /	pe, Print)	ales St.	1 1	1 41 1	.	
	J. N		31. Dete filed (Month, Day, Year)	7 6-B/		101 14. Ch	arles St.	Balt	o. Med .	2/2	-04
	Stat	e ar	MAY 0 4	2005	or's Signature	Marie					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Z-350 M 30 2005 Costello Shivers Delores /Medical 4a. Facility Name (If not institution, give speet and number),
SINAI HOSPITAL & ISAUTI WORL 4c. County of Death 4b. City. Town, or Location of Death Examiner Cit Baltimore If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12 30 3 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 25 F Yrs. Director 74 ΜĎ 216-54-3009 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Itame 23a any injury or other treumetic event, the Medical Examble must bonce. 21215 4109 Belle Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Housewife Home na 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mattie Hicks Harry Gantt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Shivers-Husband 4109 Belle Ave, Baltimore, md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/6/05 Randallstown, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21. Signature of Funeral Service Licensee 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ariest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed for as a consequence of); Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? given in Part I. 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25 or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Yes 2 No 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funaral Diractor: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

DHMH 17 Rev 1/2001

State Registrar

J. Boatten 31. Date filed (Month, Day, Year)

Division of Vital

32. Registran Signature

			Flease i	State of Manufact / Day		•	•	
			1 For State	State of Maryland / Dep		Mental Hygic	ene	I will you person on
			Registrar		rtificate of Death		No.4 UUJ	15078
	Physic	an	Decedent's Name (First, Middle, Last,			2. Date of Death Month	Day Year	3. Time of Death
	/Medi		MARJORIE		STULTZ	MAY 1, 2	005	3:30 A M
4	Exami	ner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	1	4c. County of Death	
			BRIGHTON GARDENS		PIKESVI	LLE	BAL	TIMORE
	Funeral		5. Social Security Number 6. Sec	1M 21X1E	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birthpl	ace (State or Foreign try)
	Director		212-12-4005	84 Yrs.		07/20/192	20	MD
	pue *		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	ocation		10	Od. Inside City Limits
	sho	ō						1 Yes 2 No
	he h	Director	MD BALTIMORE	OWINGS MI				λ
	with the party of	ä	10e. Street and Number	r APT. #210	10f. Zip Code	10g	. Citizen of What Count	try?
	death with the Maryland ms 23a or 28a-f show I must be notified at	Funeral	4730 ATRIUM COUR		21117		U.S.A.	
	er de item	nu	11. Marital Status 1 □ Never Married 2N Married	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
36	rs aft	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 [] No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: WH	ITE
8	72 hours after netural, or ite		15. Decedent's Edu		adont's Heural Occupation	10	b Kind of Business (last	
5	in 72	Jet	(Specify only highest grade	e completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king	b. Kind of Business/Ind	ustry
12	within ene. than "	Completed	Elementary/Secondary (0-12)	COHOGO (1-40r 5+)	MEMAKER		OWN HOME	
9	filled Hygid Sther	Ö	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai		
an	ould be Mental arked o	o Be	ISAAC	UE				
<u></u>	thoul mark mati	10	19a. Informant's Name/Relationship (Ty			ral Pouto Number, C	LONDON	Codol
Maryland 21215-0036	d 2 sho th and t7 is ma		JOHN BERNARD STULT		ing Address (Street and Wyngstep Or Ru ATRIUM COURT OW		6, MD 21117	2008)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event. Its Mudical Examinar must be notified at angle.		20a. Method of Disposition	20b. Place of Disp	The second secon		Location - City or Tov	yn State
Baltimore,	ages nt of :: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ P	emoval from State cemetery, cre	matory or other place)			
Ē	permit. Pa Departmer Important any injury		' 4 □ Donation 5 □ Other (Specify)		LOM MEMORIAL 05/03		ISTERSTOWN	
Bal	permit. Departr Imports any inj		21. Signature of Funeral Service License		2. Name and Address of Facility SO			
	40200		1100010		3900 REISTERSTOWN			
				cations that caused the death. Do not er se cause on each line.	iter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician	9 P	Immediate Cause (Final disease or condition	Metasdatic	HOGNOCUSOIN	mora		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	ADEROCAROIN			
	LXaiiiiiei		Sequentially list conditions	(asciboura	- TTP DIKOLI	2		
	ס א	Examlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
\vee	te be executed ysician and ie burial-transit	ше	triat militated events	·				
O,	e exe	Ě	resulting in death) Last	Due to (or as a consequence of):				
3760,	ate be executed hysician and he burial-transit	Ical						
68	ng ph	Physician/Med	IF FEMALE:					
Вох	th ce endii r use	an/l	23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 3	Ectopic pregnancy		23d. Date of deliver	у
. E	dea ne at ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		Month [Day Year
P.0	at the by th	hy	9 Unknown	3EI OIKIOWII				
S,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	by F	()	tributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
DI	w require been si should b	ed	fremiss.	3 ENSOKOS		1 🗆 Yes	2 ☐ No 3 ☐ Proba	bly 4 □Unknown
Records,	aw requ s been 2 shouk	Completed by	Melianost	12- Do tensio	\sim	24a. Was an	24b. Were autop:	sy findings available
R	sician: The law certificate has t irector, page 2 s	E O	H. + 0 000			autopsy	death?	pletion of cause of
Vital		Bec	25. Was case referred to medical	DOD SLEW	26 Place of Deal	1 ☐ Yes 2 ☐	No 1 □ Yes 2	: L N0
5	ding Physician: h After this certifical funeral director,	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	0		e 6 □Other (Specify)	
of	Phys er this eral di		27. Manner of Death	28a. Date of Injury 28b. Time of	of 28c, Injury at	28d. Describe how i		
on	ith. After f.ner	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	Attending r death sector: After by the fine	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st	reet, factory, office	28f. Location (Street	t and Number or Rural	Route Number.
ō	after Direction	eri	4 Homicide	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, S	tate)	
	spita ours ours filled		29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my knowledge, dea	h occurred at the time, date and place	and due to the cause	a/e) and manner as sta	tod
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	Medical	(Check only 2 Medical Examir	er: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occur	red at the time, date	and place, and due to t	he cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number	29d	Date signed (Month, D	ay, Year)
	⊢ ≯ ⊢ ō	0.000	DO AT	ok/ Inn	NIXIES		5/1/2×	***
	/	1	" Very	7 acoclery Lay	1111112		19107	_
	5		30. Name and address of person who co	ripleted cause of death (Item 23a) (Type	Print)	200		
			31. Date filed (Month, Day, Year)	32. Registrar's Signature	and Drive	300		
	Sta Registr		MAY 0 4	2005 Meser J	Gode			
			fatte / s					

			1 - State of Maryland State of Maryland		artment of H			iene _{19. No.} 200	5 15079
	Physicia		Decedent's Name (First, Middle, Last) BERTHA MONDELL		CHADIDO		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		SHAPIRO 4b. City, Town, or	Location of Deat	APRIL	30 2005 4c. County of Dea	9:42 A M
			2806 HANSON AVENUE		BALTIMO			N/	
	Funeral Director	1	5. Social Security Number 6. Sex 1 M 2 1 Age (In yrs. In 1 M 2 1 Age (In yrs.	as <i>t birthday)</i> Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/01/19	913 9. Bi	rthplace (State or Foreign PA
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Maryli -f sho	ţō		BALTIM					1√ Yes 2 No
	or 28s	Director	10e. Street and Number		10f. Zip Code		10	ng. Citizen of What C	
	eeth w	Funeral	2806 HANSON AVENUE 11. Marital Status 12. Was Decedent Ever in U.S.	3 13	21209 Was Decedent of H	Ispanic Origin? (S	necify Yes or No-	14. Race - Am	S.A.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show appring region of the traumatic event, the Medical Examinat nual termiliad at once.	by	1 Never Married 2 Married 1 Never Married 2 Married 3 Married Forces 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	o Rican, etc.)	Black, Wh	
15-0	n 72 h "natu	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	rking	16b. Kind of Busines:	s/Industry
212	d withingiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		PERSON	,		RETAIL	
	be filed Ital Hygir Id othar evant,	Be	17. Father's Name (First, Middle, Last)	WED			ne (First, Middle, N	faiden Surname)	DUOVANTZ
Maryland	should be nd Mental markad c	ဥ	LOUIS J 19a. Informant's Name/Relationship (Type, Print)	MYER		FRIEDA and Number or Ru	ıral Route Number.	City or Town, State,	BUCKANTZ Zip Code)
	1 and 2 Health ar Ism 27 Is		GERALD MONDELL / SON	2524	WILLOW G	LEN DRIV		MORE, MD 2	
altimore,	Pages 1 nent of He int: If itsn iry or oth				nsition (Name of matory or other place			20c. Location - City o	
Ħ	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) BNA		EL CONG. Name and Addres			BALTIMORE,	
B	permi Depa Impo any ir once	8 9	Mehoul Bruger			30		ON & BROS. IKESVILLE.	
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
ı	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death) a	(Ness	3				
h	Examiner		Sequentially list conditions, b.	once on.					
	ed sit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury	ence of):					
Ć.	execut in and ial-trar	Examiner	that initiated events c. Due to (or as a consequ	ence of):					
8760,	cate be executed oblysician and the burial-transit	llcal	d						
9	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnant 23c. If yes, outcome of pregnant	ncy				23d. Date of de	liven
Box	ne death the atter hed for u	slciar	in the past 12 months? 1 Yes 2 No 1 Helponar at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de ed by the detached		9 ☐ Unknown/ 9☐ Unknown/ Part II. Other significant conditions contributing to death but not resu	tting in the u	nderlying cause give	en in Part I	23e. Did tob	acco use contribute t	to the cause of death?
rds,		ed by	Crewia				1 ☐ Ye	¥	robably 4 Unknown
eco	law requires as been sign 2 should be	Completed	Coon pul sagger furin				24a. Was an		utopsy findings available completion of cause of
<u>=</u>	: The cate har, page		Sple romeguly				perform		V
Z Z	Physician: Th r this certificate ral director, paç	o Be	25. Vas case referred to medical examiner? 1 ☐ Yes 2 10 No Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatier	nt 3 DOA Othe		ath (Check only one	nce 6 Other (Spe	ecifu)
Division of Vital Records,	ding Phys n. After this funeral di	on: T		28b. Time of Injury			28d. Describe hor		scity)
isio	or Attanding after death. Diractor: Aftel in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 300 Bloco of Injury. At hor	me farm et		Yes 2□No	28f Location (Str	eet and Number or F	Jural Poute Number
<u>></u>	al or A s after il Dirac	Certification:	4 Homicide determined building, etc. (Specify,	10, 121111, 311	eet, factory, office		City or Town,		urar noute Number,
	To the Hospital or Attanding Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	vledge, death on and/or in	h occurred at the tin vestigation, in my of	ne, date and place pinion, death occu	, and due to the ca irred at the time, da	use(s) and manner a	s stated. e to the cause(s)
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Mon	th. Day, Year)
•	١.		30. Name and address of person who completed cause of death (Item	23a) (Tuno	Print)	1033 11	(4, 11	100 07.	2005
	V		A(an leftowitz, 5400 Oc	DCO	URT Rd	Suite:	205 Bens	Jaylstown	110) 21133
	Sta Registr		30. Name and address of person who completed cause of death (Item Haw Let Kow It, 5400 00) 31. Date filed (Month, Day, Year) MAY 0 4 2005	E A	pedi		1		

AKG		1 - State Unpend Item 2	State of Ma 3a,27,28a	rylan -f p	d/Depa er nee/	irtment of F	lealth a Death	and M tas	ental Hy	giene Reg. No.	005	15080
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Michael. Anth	ony Sc	rocc	а				2. Date of De April		005 ^{Year}	3. Time of Death 5:10 A M
Examine		4a. Facility Name (If not institution, give s Prince George's Ho		nter		4b. City, Town, o Cheverly		of Death			ounty of Death ince Ge	orge's
Funeral Director		5. Social Security Number 6. Sex 148–74–4302	7. Age M 2□F	(In yrs. 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Oct.12	y, Year) , 1982	9. Birthpl Coun New	ace (State or Foreign try) Jersey
death with the Maryland ms 23a or 28a-1 show rmust he notified at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10	0d. Inside City Limits 1 □Xes 2 □ No
the Ma 28a-1	ecto	New Jersey Somer	set		Bran	chburg 10f. Zip Code				10a Citian	n of What Coun	
Sa or		3 Hidden Lane					876			•	ited St	
036 urs after al', or Ite	by Funeral Director	11. Marital Status 1 🏿 Never Married 2 G Married 3 G Widowed 4 G Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕱 N If Yes, Give Year or Dates:		ĺ	Vas Decedent of H i Yes, specify Cuba	ispanic Or an, Mexica Specify:		cify Yes or No- Rican, etc.)		Race - America Black, White, e pecify: Wh	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or any Injury or other traumatic event, the Medical Examples.	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		+)	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired	ation during mos i)	st of workin	ng l		of Business/Ind	·
d 2-	0	17. Father's Name (First, Middle, Last)	4		be	pendent	18. Mothe	er's Name	(First, Middle,			pporting
/lan	To B	Anthony Scrocca			_		Ma	ry Ka	essing	er		
Mary 12 sho h and I		19a. Informant's Name/Relationship (Typ				g Address (Street				-		·
re, N s 1 and I Health item 27 other tr		Anthony Scrocca , 20a. Method of Disposition		20b. P	lace of Dispos	dden Lane sition (Name of			ourg, N		rsey 08	
Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State			s Cenetery		05/04	/05	Bridg	ewater,	New Jerse
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any Injury or other		21. Signature of Fundal Service License		0111	3	. Name and Addres		Dra		~	eral Ho	me
ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	edical Examiner	23a. Pant1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Final that initiated events resulting in death) Last	Smoke in Due to (or as a Due to (or as a	e. hala consequ	uence of):							Approximate Interval Between Onset and Death
P.O. Box 6 nat the death certifi d by the attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)				23d	Date of deliver Month	y Day Year
rds, P.O. I	þ	Part II. Other significant conditions con	tributing to death bu	t not resu	ulting in the un	nderlying cause give	en in Part I	l.	4			a cause of death?
The The page	Completed								Yes	sy rmed? 2 \Begin{align*} No	prior to com death	sy findings available apletion of cause of
of Vita Physician: This certifici	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatier	nt 2 X	ER/Outpatien	t 3□ DOA Oth	0.0		(Check only o		Other (Specify,)
on of ding Physics : After this funeral di	on: T	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Injun World	at k?	2	8d. Describe h	ow injury o	ccurred	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	4-30-05 28e. Place of Injurbuilding, etc. House	ry - At ho	me, farm, stre		Yes 2 🛣	2		Street and N	se fire Jumber of Rural 507 Prin 500 MD	Route Number. nceton Ave.
e Hospits 124 hours 6 Funeral letely filler	Medical C	29a. Certifier (Check only one) 1 Certifying Phys XX Medical Examin	ician: To the best of	examinat	wledge, death lion and/or inv	occurred at the tin estigation, in my o	ne, date an pinion, dea	nd place, a	nd due to the o	ause(s) an	d manner as sta	ited. the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier	11	A. 010		29c. Licenso					igned (Month, E	
		30. Name and address of person who con	inpleted cause of de	ath (Item	23a) (Type, I	Print) 11 Penn	Stree	et. Ba			· · · · · ·	21201
Stat Registra		31. Date filed (Month, Day, Year), 0 4	2005 Registr	s Signal	ture &	June		,		,	<u> </u>	

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200. 10.30 AM /Medical 4c-County of Deeth Neme (If not institution, live street and number) 4bc City, Town, or Location of Death Examiner MIC 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 3 2/3-/4-45/2 Usuel Residence of Decedent Yrs. Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State *ohe r than "natural", or Items 23a or 28a-f eho: the Medical Examinar must be notified at BalHMORE 1 Yes 2 No Director MYONE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 238 HVENUE Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Ite any niury or other traumatic event, the Medical Exament 1 Yes 2 No If Yes, Give Year or Dates: 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 2 No Specify: Whit 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME Home maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be EKIELSKI BERTHA Zarzyek 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cometery, crematory or other place) Case WOLKER Dalto O/aND A 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State la ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Home, P.A eny ir SLOW Rd. DIING 11/0W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Itherosclevo 1Pars disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month should be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Dunknown δ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 2 8 No 1 Tyes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated ij 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who simpleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Strem & Speck

ORIGINAL

DHMH 17 Rev 1/2001

Skretowicz

1 - For State Registrar

Physician /Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Brighton Gardens

Florence Crighton Skretowicz

4a. Facility Name (If not institution, give street and number)

	Funeral Director		5. Social Security	9887	6. Sex 1 □ N	4 2 ⊠ F	7. Age (in yr			Months		Hours	Min.	8. Date o (Month May 1	. Dav. Yea	912	Co	pplace (State untry) tland	or Foreign
	and w		Usual Residence	of Decedent 10b. County			10c. (City, Town	or Loca	ation								10d. Inside (City Limits
	Maryla f eho	ō	D.C.	, , ,	_			shing		211011									s 2 No
	28a-	ect	10e. Street and N	umber			was	SIITIIB	COII	10f. Zip	Code				10a. (Citizen of \	What Co	untry?	
	With Ba or	Funeral Director	4604 Day		Stre	et.	N.W.				016					nited			
	death ms 2:	era	11. Marital Status			. Was Dec	cedent Ever in	U.S.	13. W			lispanic Or an, Mexicai	igin? (Spe	city Yes o		14. Rac	e - Ame	rican Indian,	
0	or ite		1 🗌 Never Ma	rried 2 Marri	ed	Armed F 1 ☐ Yes	21X No			Yes, speo ∐Yes				Hican, etc.	.) '		ck, White	e, etc.	
3	ours ral',	d by	3 🔯 Widowed	4 Divorced		If Yes, G Year or E	Dates:		''		ZIZI NO	Specify:				Specify	W	hite	
5	s 1 and 2 should be filed within 72 hours efter death with the Maryland if health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if e Maryland Examiner must be incillined at	Completed	(Spe	15. Decedent ecify only highes)	16a.	(Give k	ent's Usua and of wo ONOT us	rk done	during mos	st of worki	ng	16b.	Kind of B	usin <i>e</i> ss/	Industry	
4	withly ene. than	duic	Elementary/Sec	condary (0-12)		College ((1-4or 5+)	Но		aker	30 10(110)	ω)			70	wn Ho	me		
Y 5	filed Hygi other ent, I	Be Co	17. Father's Name	e (First, Middle,	Last)							18. Moth	er's Name	(First, Mi	ddle, Maid	en Suman	ne)		
0	fental fental rked tic ev	To B	William	Mudie								Jean	Sel:	lers					
ם ح	should have		19a. Informant's i	Name/Relations	nip <i>(Type</i>	, Print)		19b.	Mailing	Address	(Street	and Numb	er or Rura	l Route N	umber, City	y or Town,	State, Z	(ip Code)	
2	and 2 salth in 27 I		Phyllis A	A. Ferna	andez	z/ Fr	iend	46	04 I)aver	npor	t Str	eet,	N.W.	, Was	hing	ton,	DC 20	016
<u>ט</u>	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		20a. Method of Di	isposition 2 🛣 Cremation	3 ⊟Ben	noval from	L.	. Place of cometer MO	Disposi y, crema	ition (Nar	ne of other plac	ce)	0	ate	20c.	Location -	City or	Town, State	
	Pag ment lant: jury c		` 4 □ Donation	5 Other (S	oecify)			emat	orıı	ım, J	Lnc.	ļ ľ						Maryla:	
ם מ	permit Depart Import any in		21. Signature of	Funeral Service	icen e	1			22. Ret	Name ar	nd Addre	ss of Facili hevv	ity Rob Chase	ert A In	c. 75	mphre 57 W	y Fu isco	ıneral nsin A	Home
	40 = e d		222 824 724	the/disease, or	oomplied	-	M00689	ath Don	ot onto	Beth	esda	, Mar	ylan	d' 208	314-3	501		nsin A	
			23a. Part 1. Antel shoot, or re Immediate Cause	ead/tailure. List	only one	cause on	each line.	atti. Dor	iot eritei	i the mod	19 ог аун	ig, such as	cardiac o	пезрпан	ny anest,			Interval Be Onset and	etween
ď	Pnysician /Medical	ľ	disease or condit resulting in death	tion	a		umonia										-		
	Examiner					Due to	o (or as a cons	equence (or):										
		Jer	Sequentially list of any, leading to cause. Enter United	conditions, immediate	b	Due to	o (or as a cons	equence (of):										
	cuted nd ransit	amir	that initiated ever	11.5	C														
ĵ	e exection artical-tu	Exc	resulting in death) Last		Due to	o (or as a cons	equence	of):										
00/00	ate b	lica			d														
9	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	leted by Physician/Medical Examiner	IF FEMALE:		230	. If ves. o	utcome of preg	nancy								234 Da	te of del	ivon.	
ממ	atten atten	clan	23b. Was deceded in the past 1	12 months?		1 Live	birth 2 F	etal death		Ectopic pi Other (sp		у			_		onth	Day	Year
į	t the d by the achec	hysi	9 Unknov			9□ Unk	nown				,,								
,	s that	oy P	Part II. Other sign	nificant conditio	ons contr	ibuting to	death but not r	resulting in	the un	derlying o	ause grv	en in Part	I.	23 <i>e</i> .	Did tobacc	o use con	tribute to	the cause of	death?
cords,	en sig	per	Dementi	a											1 🗌 Yes	2 X No	3 □ Pr	obably 4	Unknown
ב כ	≥ □ ∽	Ο.								_		_			Was an autopsy	24b.	Were au	topsy finding	s available
	The cate h	Com												1 🗆 Y	pertormed:	?	death?	2 No	
VII	Physiclan: r this certific ral director,	Be	25. Was case ref examiner?	erred to medical		spital:					O#	OF.	e of Death				Acc	sisted	
5	Phys this ral dir	5 T:	1 Yes 2		110	. 1	Inpatient 2 e of Injury	28h 1	tpatient Time of		JA				Residence		iei (Spei	Li	ving
5	ding th. After fune	tlon	1 X Natural 2 ☐ Accident	5 🗌 Pendir		(Mo	onth, Day Year,		njury	М	28c. Injui Woi 1 □	rk?]Yes 2.□				,,u., y 000u			
<u> </u>	Atten r dear ector	Certification:	3 Suicide	6 Could	not be	28 <i>e</i> . Plac	ce of Injury - A	t home, fa	rm, stre	et, factor	y, office			28f. Locati	ion (Street	and Numi	ber or Ru	ıral Route Nu	mber,
5	s afte	Cert	4 🗌 Homicid	9		Dull	ding, etc. (Spe	эсну)						City	r Town, St	at 0)			
	l hour uner	edical (29a. Certifier (Check only				he best of my l												(e)
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medi	one)			and ma	inner stated.												(5)
	o Jiji	1	29b. Signature a	na title of certifie	7 -	اسله	\bigcap \sum_{i}		1 1			se number						h, Day, Year) -	
ű	N/		N	J.7	C) [[01	nen	, N	-	D420	721			ма	у 3,	2003		
	10		D. Scot	dress of person t Cohen:							ie, i	¢930.	Chev	y Cha	ase,	Mary]	Land	20815	
	Sta	ate	31. Date filed (M	bash Day Vand		00	Designation of							•		,			
	Regist			M	AY 0	4 20	55 EL	مصرو	Jan .	1	234								
DU	111147 0 416	004																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Chevy Chase

2. Date of Death Month May

Day

2005

4c. County of Death

Montgomery

3. Time of Death

 A^{M}

1:20

			1 - State Registrar	State of Maryla			of Health a			gienę Reg. No.:	2005	15083
ı	Physicia		1. Decedent's Name (First, Middle, Last) John G. Scha	arf, Jr.					Date of Dea Month April	Day 28	Year 2005	3. Time of Death 2:50 - AM
	/Medic Examin	_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, To	wn, or Location	of Death			County of Death	
			5223 King Charles				Bethesda				Montg	
	Funeral		5. Social Security Number 6. Sex 103	M 2□F 7. Age (In yr.	s. last birthday) Yrs.	If Under 1 \ Months D	ear If Under ays Hours	Min.	. Date of Birt (Month, Day	y, Year)	9. Birth	plece (State or Foreign intry)
	Director		Usual Residence of Decedent	00				S	ept. I	2,19	36 Wash	ington D.C.
	nyland how		10a. State 10b. County	10c. (City, Town or Lo	ocation						10d. Inside City Limits
	Ba-1 s	cto	Maryland Montgome	ery		Bethes	sda					1 ☐ Yes 2√ No
	with the	Dire	10e. Street and Number 5223 King Charles	Llow		10f. Zip Co	ode 20814			_	zen of What Cou ed Stat	•
	ns 23e	Funeral Director		12. Was Decedent Ever in	U.S. 13.			igin? (Specif			14. Race - Amer	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23e or 28e-f show amportent: if item 27 is marked other than "neturel", or items 23e or 28e-f show appringing or other treumatic event, the Netical Eventrical must be notified at once.	by Fun	1 □ Never Married 2 \ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yes 2 ②	t of Hispanic Ori Cuban, Mexicar No Specify:		can, etc.)		Black, White Specify: Wh	, etc.
21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade			dent's Usual C	occupation	t of working		16b. Kir	nd of Business/li	ndustry
2	ithin 7 ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use i	etired)	t dr working			E-1	
7	iled w Hygier ther th	Co	17. Father's Name (First, Middle, Last)	4	Sale	s Marke		ar's Name /	First, Middle,		vertisi	ng
Maryland	d be f ental h ked ol	To Be		Scharf, Sr	•			elen	ii si, iviiodie,		Cullum	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (S	treet and Numbe	ər or Rural F	Route Numbe	r, City or	Town, State, Zi	ip Code)
2	and 2 ealth a n 27 l		Judith Solomon /		and the second		Charles			sda,	MD 20	014
Baltimore,	ges 1 it of H if itea or oth		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Re	emoval from State	Place of Dispo cemetery, crea	matory or othe	r place)	Dat			cation - City or T	
Ξ	lit. Pa intmen intent: njury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligense 				natory		05	Ве	ltsvill	e, MD
Ba	permi Depa Impo any ir				B	lapp Fu	neral a	nd Cre	mation	n Se	rvice	0
	^		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the de	ath. Do not en	33 Gis	t AVC. f dying, such as	Silve: cardiac or r	r Spri espiratory ar	ng, rest,	MD 2091	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		atio Ho	natoco1	lular (aroin	Om a			Onset and Death 1 month
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	-				-		
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons		ocellu.	lar Caro	cinoma				3 months
	uted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
ó,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a cons-	equence of):							
8760,	icate be executed physician and s the burial-transit	dica	d									
9 x	death certific e attending p id for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 2:	3c. If yes, outcome of preg	nancy						23d. Date of deliv	/AD/
. Box	death e atter	by Physician/Medical	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time o		⊒Ectopic pregr ⊒ Other <i>(speci</i>					Month	Day Year
P.0.	that the de led by the a detached f	Phys	9 🗆 Unknown	9□ Unknown								
Ś	w requires that been signed should be det		Part II. Dther significant conditions con	inbuting to death but not r	esulting in the u	inderlying caus	se given in Part I	•		obacco u /es 2	_	the cause of death?
Vital Record	aw 1s t	Completed							24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
alF	Th ate pag								1 Yes	rmed? 2X No	death?	2 No
		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	iospital: 1 Inpatient 2	□ EB/Outpation	nt 3 🗆 DOA			Check only o		S □Other (Spec	(6.4)
on of	Attending Physic death. sctor: After this by the funeral di	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)			Injury at Work?	280	d. Describe h			iiy)
Division	il or Attending Phater death. Director: After that in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe		reet, factory, o	ffice	281	f. Location (S City or Tow			ral Route Number,
	To the Hospital or At within 24 hours after of to the Funerel Direct completely filled in by	edical C	29a. Certifier XXCertifying Physic (Check only one) 2 Medical Examination	sician: To the best of my kner: On the basis of exami	nowledge, deat nation and/or in	h occurred at I	he time, date ar my opinion, dea	nd place, and ath occurred	d due to the a	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the h within 2 To the f complet	Me	29b. Signature and title of certifier	100			icense number			29d. Date	e signed (Month	, Day, Year)
)	1 V/n	/	MANNEY	MUN M		D	21531			Apr	il 28, 2	2005
16	01/	3	30. Name and address of person who co G. Peter Pushkas				Rd.; R	ockvil	lle, M	D :	20852	
	Sta Registr		31. Date filed (Month, Day, Year)									

JET 05-02993 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James G. Smith State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Year April 2005 James Goodman Smith 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2402 Ash Grove Lane #103 Ocenton
| funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 119M 20 F 51 Yrs Director 02/24/1954 CT 046-46-3905 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be natified at Completed by Funeral Director MD Anne Arundel Odenton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Items 23a 2402 Ash Grove Lane, #103 21113 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: if item 27 is marked other then "netural", or Items 23a ray or other treumatic event, it is Macked Examilian in the 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ 10 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Journalism Elementary/Secondary (0·12) College (1-4or 5+) Photographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Goodman Nina 2 Randolph C. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Smith / Wife 221 Stoney Run Lane Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2. Cremation 3 ☐ Removal from State May 3 permit. Page Department of Importent: If any Injury or once. * 4 □Donation 5 □ Other (Specify) Chesapeake Crematory Inc. 2005 Beltsville, Maryland 22. Name and Address of Facility Cremation and Funeral Alternatives 1400382 8717 Green Pastures Drive Baltimore, Maryland 21286 Sydamaann 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** CIRRHOSIS OF resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading of in reclassicause. Enter Underlying Cause (Disease or injury Due to (or as a consumence of Examiner nding physician and use as the burlal-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an

Completed by Be

Certification: To

this After after death filled in by

within 24 hours a Medical State

25. Was case referred to medical examiner?

examiner? 1X Yes 2 No 27. Mann r of Death 1 atural 5 Pending 2 Accident 3 ☐ Suicide 4 Homicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

investigation 6 Could not be determined

one

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital:

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

OCME

29c. License number

Other:

1 □ Yes 2 □ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

May 1 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 □ No

Yes

autopsy performed?

2 🗆 No

28d. Describe how injury occurred

Yes

26. Place of Death (Check only one)

P

e (State or Foreign

1 Yes 2 No

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARYDRITO 31. Date filed (Month, Day, Year)

KUREL 32. Registrar's Signature

111 Penn Street Baltimore Maryland 21201

Registra

			For State Registrar	State of Ma	aryland		artmer <i>rtificat</i>			and M		jiene eg. No. 🤈	00	7	.000
	Physici: /Medic		Decedent's Name (First, Middle, L Max	ası) Erwin Turne	er						2. Date of Dea Month April	th Day 29	Year 200		52A M
	Examin		4a. Facility Name (If not institution, g Laurel Region		1			Town, or	Location of	of Death			ounty of De		
	Funeral Director		5. Social Security Number 6. 514-20-0700		e (In yrs. Ia. 78	st birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day NOV . 6	, Year)	_	irthplace <i>(Stat</i> Coun try) ansas	le o <i>r Foreig</i> n
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD Howard	 d		Town or Lo	ocation								City Limits es 2 1 No
	h with the	al Director	10e. Street and Number 8449 Old Co	lumbia Road			10f. Zip	Code 207	23			USA	n of What (Country?	
036	be filed within 72 hours after death with the Maryland ital Hygiene. A other then "natural", or theme 23s or 28e-f show event, the Medical Example of most be motified at	by Funerai	11. Marital Status 12. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	195	4-	Was Dece If Yes, spe 1 Yes	dent of Hi cify Cuba	spanic Ori	i, Puerto	ecify Yes or No- Rican, etc.)	14	Black, Wh	nerican Indian nite, etc. White	•
215-0	ithin 72 ho ne. nen "natur:	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		5+)	(Give life.	dent's Usu kind of wa DO NOT u	se retired	luring mos	t of worki	ing	16b. Kind	of Busines	s/Industry	
Maryland 21215-0036	e filed I Hygi other vent, I	To Be Cor	12th 17. Father's Name (First, Middle, Lateral Joe Turner	4st)		Eng	ineer	•			(First, Middle,		onaut; umame)	ical	
Mary	nd 2 should be a lith and Mental 27 is marked o r traumatic eve	Ĕ	19a. Informant's Name/Relationship Nancy Ferreira/N						and Numbe		A Route Numbe		own, State	, Zip Code)	
timore,	permit. Pages 1 and 2 should be Department of Health and Mente Importent: If Item 27 Is marked any injury or other traumatic engines.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State		ce of Disponetery, cre	osition (Name matory or o	me of other place	θ)		Date	20c. Loca		or Town, State	
Balt	permit. Departn importe any inju		21. Signature of Funeral Service Lic		00770						naldson , Laure	Fune	eral E	Home, P	P.A.
	Physician /Medical		23a. Part1. Enter the disease) or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each li	_{ne.} rebra	l Thr			g, such as	cardiac o	or respiratory an	est,		Approxin Interval I Onset ar	Between nd Death
	Examiner pu	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events	b. Due to (or as	a conseque	ence of):									
68760,	icate be executed physician and the burial-transit	dicai	resulting in death) Last	Due to (or as	a conseque	ence of):									
O. Box	The law requires that the death certificate be executed to has been signed by the attending physiclan and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3[⊒Ectopic pi ⊒ Other (sp					236	d. Date of d Month	lelivery Day	Year
rds, P.	quires that n signed b uld be deta	þ	Part II. Other significant conditions Atrial Fibril	_	ut not resul	ting in the u	underlying o	ause give	en in Part I.			bacco use es 2 🗆		to the cause of	of death?
Reco		Completed	Mitral Valve	Disease		-					24a. Was a autop: perfor 1 Yes	sy	prior to death	autopsy findin o completion o ? as XX No	gs available of cause of
Division of Vital Record	Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 Yes 2XXIo 27. Manner of Death	Hospital: 1XXInpatie 28a. Date of Inju (Month, Da		R/Outpatie		Othe 28c. Injun	er: 4 □ Nu	ırsing Ho	n (Check only or me 5 ☐ Resid 28¢. Describe h	ence 6 [pecify)	
ivision	i or Attending Ph atter death. Director: After th I in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide	ton 28e. Place of Inj		Injury ne, farm, st	М	1 🗆 '	Yes 2		28f. Location (S City or Tow		Vum <i>ber or</i>	Rural Route N	lum <i>ber,</i>
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edical Ce	29a. Certifier Certifying (Check only one)	Physician: To the best aminer: On the basis o and manner st	f examination	ledge, deal	th occurred	at the tim	ne, date an pinion, dea	nd place, a	and due to the deed at the time, o	ause(s) ar late and p	nd manner lace, and d	as stated. ue to the caus	e(s)
	To th within To th	Me	29b. Signature and title of certifier	Allan	ren.	m	29	c. License	391	16	1		_	nth, Day, Year	
3	0117			ren, 321 Pr	ince	Georg	,	eet,	Lat	urel,		707			
	Sta Regist		31. Date filed (Month, Day, Year)	4- 2005	ar's Signatu	8 -	down	2							

Registrar

21		1	For State Registrar	State of Marylan		artment of H				Reg. No.	05	15087
	Physici	100	Decedent's Name (First, Middle						Date of De	21, Day 200)5 Year	3. Time of Death 10:05 A M
	/Medic Examin		ANTHONY 4a. Facility Name (If not institution Prince George	LEE TIMMONS give street and number) s Hospital Cente		4b. City, Town, or Cheverly			L	4c. Coun	ty of Deat	
Ī	Funeral Director		5. Social Security Number 220–82–0948	6. Sex 125M 2 F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da April	th ly, Year) 8 1974		hplace (State or Foreign buntry)
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event, Ita-Mydical Examiner must be notified at	Funeral Director	MD Prince	George's I	Landove	10f. Zip Code				10g. Citizen o	4 What Co	1XYes 2 No
	3a or 3	i Di	7519 Allendale	Drive		20785				U.S		ountry :
	r death	nerg	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi		gin? (Speci	ify Yes or No ican, etc.)			nican Indian, e, etc.
30	irs afte	by Fu	1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes Give		1 ☐ Yes 21 No	Specify:				aify: B 1	ack
9500-61212	72 hou nature			t's Education st grade completed)	16a. Dece	dent's Usual Occupa	ation Juring most	t of working	2	16b. Kind of	Business	(Industry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	no not use retired, chouse Mar)			Priv	vate	
ב ה	e filed other vent,	Be Cc	12th 17. Father's Name (First, Middle,	Last)	Walt	nouse nar		er's Name (First, Middle	, Maiden Sum		
Maryland	should be and Mental semarked o	ToE	Lee F. Timmor						oberts			-
Mar	0 £ N #		19a. Informant's Name/Relations Lee F. Timmons		1	ng Address (Street a						
	es 1 an of Heal itam 2 r other		20a. Method of Disposition	20b. I		osition (Name of matory or other place		Da		20c. Location		
altimore,	Page tment tant: If		1 🕱 Burial 2 □ Cremation `4 □ Donation 5 □ Other (S	Specify) Co	edar Hi	ill Cemete	ery !	5/2/0		Suitla		
Bai	permit. Pages Department of I Important: If its any injury or ot		21. Signature of Funeral Service	Licase		2. Name and Addres				nkins F		
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that saused the dea only one cause on each line.							y Lanc	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a BUNSHOT W	MUUM	OF NEG	K W	ITH	COMPL	ICATTOR	3	Onset and Death
ŀ	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):							
		ner	Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury	b. Due to for as a conser	quance or).							
	ate be executed thysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):							7
8760,	sician sician buria		-	d d	quonos on.							
Ö	certificate be executed iding physician and ise as the burial-transit	Medic	IF FEMALE:									
Вох	atter for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet: 4 Pregnant at time of	al death 3[Ectopic pregnancy Other (specify)				T.	Date of del Month	livery Day Year
О	at the de by the a	hysi	9 Unknown	9□ Unknown								
	as the gned	by	Part II. Other significant conditi	ons contributing to death but not re-	sulting in the u	inderlying cause give	en in Part I.	٠		tobacco use co Yes 2 5 4No		the cause of death?
Records,	w require been si should I	Completed							24a. Was			utopsy findings available
	The lay ate has page 2	omo							auto perfe 12 Yes	ormed?	prior to death? 1 XYes	completion of cause of 2 □ No
Vital	Attending Physician: The rideath. sector: After this certificate hiby the tuneral director, page	Be	25. Was case referred to medica examiner?	Hospital:		Othe	200		(Check only			
ō	g Phya ar this eral dii	n: To	1 XYes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie	nt 3LI DUA	4 Nu	-		idence 6 □C how injury occ		cify)
sion	eath. or: After tuner	catio	1 Natural 5 Pendii 2 Accident investi 3 Suicide 6 Could	igation 4/15/05	5:30	44 4 7			SUBTE			SHOT
Division of	or Attendate death Diractor:	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☑ Homicide determ	building, etc. (Spec	nome, farm, st ify)	reet, factory, office			City or To	wn, State)		ural Route Number,
_	ospital hours unaral ly filled	edical C		ng Physician: To the best of my kn Examiner: On the basis of examin and manner stated.				id place, ar	nd due to the	cause(s) and	manner as	
)	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifie) \		29c. License OCME	e number			29d. Date sign April 2		
1	11		30. Name and address of person	who completed cause of death (Ite	em 23a) (Type	•	Penn	Stree	t Re	ltimoro	Mor	cyland 21201
	St Regist				nature		r CIIII	DELEG	u Da.	гетиоте	, rial	<u>yıanu 21201</u>
					-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Thomas 2005 10/ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington 13106 Hyacinth Court Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Oct. 7, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🙀 F Yrs. 213-20-7634 80 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. Count 7 is marked other than "natural", or items 23a or 286-1 show troumetic event, the Medical Example matrice as 1 ☐ Yes 2 No by Funeral Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Court 21742 13106 Hyacinth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after c Health and Mental Hygiene. 3m 27 Is marked other than "natural", or Iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Kist Madeline Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health a Importent: If item 27 Is any injury or other treuonce. Thomas- Son 13106 Hyacinth Court Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial | 5/4/05 Elkridge, Maryland Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. Heather 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 5 esidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Hospitel or Attending Pl 24 hours after death. Funerel Director: After the Certification: 1 Natural 5 Pending investigation 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 464

State Registrar address of person who completed cause of death (Item 23a) (Type, Print)

OLM.

m)

2. Registrar's Signature

		_	For Stata Registray MIZNID ITEM	#8 PER FH C	ryland / Dep 3843 5/05			Reg	ene 2005	15089
	Physicia	an	Decedent's Name (First, Middle, I	.ast)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	PHILIP 4a. Facility Name (If not institution, g	ing atract and pumbar		TROST	r Location of Death	APRIL 29	9 2005 4c. County of Death	11:10 A ^M
	Examin	er	RUXTON PIKESVIL		HOME	PIKESV			BALTIMORE	
_	Funeral			Sex 7. Age	(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	O1 / 9 Birthe	place (State or Foreign
	Director		058-05-2476 Usual Residence of Decedent	1 X M 2□F	90 Yrs.	Months Days	Hours Min.	8. Date of Birth 1 05/15/200	75	POLAND
	f show	ō	10a. State 10b. County MD BALTIN	10pF	10c. City, Town or L BALTIMOR				1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	128e-	Funeral Director	10e. Street and Number	IONE	DALITHON	10f. Zip Code		100	. Citizen of What Cour	
	h with	ai D	2719 WOODCOURT F	ROAD		2120	19		U.S.A.	
	ems ems	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	can Indian,
	within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 28e-f show the Medical Examinar must be motified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 🗋 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☐ No	Specify:	,	Specify: WH	
	72 ho	eted	15. Decedent's (Specify only highest of	Education grade completed)	16a. Deci	edent's Usual Occup e kind of work done	pation during most of work	ina 16	b. Kind of Business/In	dustry
1	within ane. than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+	+)	TORY WORK	during most of work d) 'FR		APPLIANCES	
1	Hygie Hygie ther	ပ္	17. Father's Name (First, Middle, La	st)	170	TOKY WORK		e (First, Middle, Ma		
Mai yiaila 21213-0030	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Presented the fire 21 is marked other than "natural," or flems 23a or 28e-f show any injury or other treumatic event, the Madical Examinal must be notified at once.	To Be	HARRY			TROST	ANNA			OTNICK
Z	12 sh h and 7 is m treum		19a. Informant's Name/Relationship			ling Address (Street WOODCOUR			City or Town, State, Zip	Code)
ב ע	1 and Healt em 2		JOSEPH TROST / E 20a. Method of Disposition	BROTHER	20b. Place of Disc	osition (Name of	1		, MD 21209 c. Location - City or To	own. State
Dalillioie,	ages int of t: If it		1 🛣 Burial 2 □ Cremation 3		MT. LEBA	ematory or other pla	,		LENDALE, N.	
	nit. P artme ortan injur.		*4 □Donation 5 □ Other (Spe 21. Signature of Humanal Septice Lice						N & BROS.,	
Š	Depa Impo any ir		1 standen	na					KESVILLE, N	
Ì	Physician		23a. Pan1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death YEARS
	/Medical Examiner		vocating in dodain,	Due to (or as a	consequence of):					
-	icate be executed physician and s the burial-transit	ical Examiner	Sequentially list conditions, if a y, tracing to the rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):					
.O. BOX 60	death certif e attending d for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at to 19 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delive	ery Day Year
, CD	juires that n signed b iid be deta		Part II. Other significant condition	s contributing to death bu	at not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the	he cause of death?
	. The law requires that the sate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe	prior to co	ppsy findings available impletion of cause of
	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		O#		th (Check only one)		
5	Phys r this ral dii	: To	1 Yes 2) No 27. Manner of Death	1 ☐ Inpatier				ome 5 Resident	ce 6 Other (Specification)	(y)
	Attending Phy r death. ector: After thi by the funeral o	ation	1 Natural 5 Pending investiga	(Month, Day tion	Year) Injury	Wo			,,	
	of or Attendation after death	Certification:	3 Suicide 6 Could no 4 Homicide determin		iry - At home, farm, s . <i>(Specify)</i>	street, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical		Physician: To the best of teminer: On the basis of and manner state	examination and/or i					
	To t. To tl	M	29b. Signature and title of certifier			29c. Licens			I. Date signed (Month,	
	0		30. Name and address of person w	nd completed cause of de	eath (Item 23a) (Type	a, Print)	037573 Reistrasta		Irs lingA	2000
	7		set ribt	MD -3	25 Maria	, St. 1	Reisterate	on N	10 2113K	
	Sta Registr		31. Date filed (Month, Day Year)	4 2005 32. Phiistra	r's Signature	godin				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 23a b 25 per doc 850 12-7-05 vt.

State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 8:10 PM M Obadiah Thompson, Sr. May 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1. MM 2□ F Yrs. Director 233-34-6322 06/15/1922 w Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 7 is marked other than "naturel", or Items 23e or 28a-f shov treumatic event, the Medical Examinat must be notified at 1 Yes 2 No Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5110 Richard Avenue 21214 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Keyes 2 DNo If Yes, Give Year or Dates: 1945-1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. If Item 27 is marked other than "naturel", or Iter any Injury or other treumatic event, the Medical Exercities. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Ship Yard Elementary/Secondary (0-12) College (1-4or 5+) Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thompson Marv Belcher 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalee Thompson/ Wife 5110 Richard Avenue Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 5 2005 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives Aplu D' Xolimann 1100382 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastalic cances months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Mesothelioma Due to (or as a consequence of) Examiner requires that the death certificate be executed Asbestosis Due to (or as a cons attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 20 1 Yes To the Hospital or Attanding Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D24170 LSO NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 N. Eutaw St Baltimore, MD 21201 Hospice 150

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23a,25,27,28a-fper MF, G843,0503,050hb
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year MARY Month hysician WHETZEL 1:48 P M MARCH 12 2005 *∀* /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City-Town, or Location of Death Examiner Kandallst NORTHWEST Kaltimore HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 8. Date of Birth Birthplace (State or Foreign
 Country) **Funeral** Days Washington DC Months Hours 1 M 2 □ F 218-34-598 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-f shor traumatic event, the Medical Expriner must be traitined at Baltimore 1 ☐ Yes 2 No Completed by Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3216 venue A should be filed within 72 hours after dea th and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 V No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1) isablea YR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Heelth and Mental I. Important: If Itam 27 Is merrany or other. Be Choren Allan ane toller 9 ame/Relationship (Type, Print) 19a. Informan 's 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aldie POST OFFICE Bruther Box 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State *sreenmount* * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rughy C Greene Funeral SINCS 21. Signature of Funeral Service License Vaugh Rd. Kandallstown, MD 23a. Part1. Enter(the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANOXIC BRAIN Prosician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PULSELESS ELECTRICAL ACTIVIT Sequential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine sicien and burial-transit The law requires that the death certificate be executed CATION APPROVED BY MEDICAL EXAMINER CHOKING 于00万 0 N resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical CERTIF the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) signed by the a P.O. | 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Diabetes; Chronic Obstructive Lung Disease 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this After thi 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: T Natural 5 Pending investigation 1 ☐ Yes 2 🛣 No March 11,05 Unknown Subject choked on food death. 2 XAccident neral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours effer of To the Funeral Direct completely filled in by 4 Homicide Gingerbread Manor, 3216 Taylor Group home GLOUP NOTICE

AVE. Balto MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D54352 MARCH 12 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA TODOR Or D flospithe Shot PLANDALLSTOWN NORTHWEST OLD COURT ROAD 21133 31. Date filed (Month, Day, Year) State MAY 0 3 2005 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OSPM Month Year **Physician** Je5518 $\alpha \Pi$ 200 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Centre Baltimor If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2007 Yrs. Director 216-14-7030 Aug. Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercities must be notified at Director Maryland Baltimore 1 ☐ Yes 2 ☐No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with 1s and Mental Hygiene. Is markad othar than "natural", or Itams 23a or 3 7569 Westfield Road 21222 Completed by Funeral United States 12, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🍇 🖾 No Specify: Specify: White 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allan S. Anderson Martha E. Miller 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an Robert D. Wyatt (Son) item 27 Rua Cardoso De Almeida 1623 Sao Paulo, SP 05013-00 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Dopation) 5 Ø Other (Specify) Air Mem. Gdns. 5/2/2005 Bel Air, Maryland 21. Sign ture of Aurica Service ice 2. Name and Address of Facility Muda-Ruck Funeral al Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final multi-Pnysician DAEUMONI days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death. To the Funeral Director; A 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29c. License number 29b. Signature and title of 0 30. Name, and address of eted cause of death (Item 23a) (Type, Print) Venue

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY

2005

amend Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** Sarah Wylie Woodard 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore of Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) SC 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 XF Min. Days Hours 217-60-129 52Yrs. Director Usual Residence of Decedent 72 hours efter death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28e-f show the Medical Examinar must be notified at X Yes 2 No Director MD Baltimore 2408 Loyola Northway APT. 102 10g. Citizen of What Country? 10f. Zip Code items 23e 21215 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No 0 Specify: Specify:Black 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cook Hotel other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be 1 and 2 should be fit Health and Mental H Roosevelt Foster Ellen Woodard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Ernest Davis 1520 N. Patterson Pk. Balto. 21213 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
eny injury or ott 1 XBurial 2 Cremation 3 Removal from State Sacred Heart * 4 □ Donation 5 □ Other (Specify) 5-06-05 Dundalk, MD 22. Name and Address of Facility Wesley Chavis Jr. FH 2007 Eastern Ave. Balto. MD. 21231 23a. Part1. Enter the disease or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician small Cell l mondhs disease or condition resulting in death) Jan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): 68760 that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by requires 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive pulmonany disease, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No , history of 24a. Was an Intravenous Hepatitis C Use, 25. Was case referred to medical Desp Versus Thombosis, tebacio use certificate 2 X No 1 Yes Vital the Hospitel or Attending Physicien: Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ٩ this 28c. Injury at Work? 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide filled within 24 hours a To the Funerel D 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smai Hospital CATHERINE MILLNTIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY 0 4 2005

Sorah Woodard

Knawn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Olivia Mary 2005 2303 PM toni <u> 30</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington Co. Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
01 25 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M **%**□F Director 88 MD 213**-**36**-**0698 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other treumatic event, the Modical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes XXNo MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth to Department of Health and Mental Hyglene, importent: If Item 27 is marked other then "natural" any injury or other treumatic according. 21740 9902 Stephanie Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specity: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private llth grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Griffin Nellie Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9902 Stephaine Lane, Hagerstown, Md 21740 Donald Griffin-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 5/7/05 Arbutus, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician bacterial days Nosocomial phelimonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown you dehicency anema, acute rehal facture, wrigary trust page 2 should Completed Obstructive 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 【 No pulmmary 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 📢 o 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Director filled in by à 4 Homicide

P.O. Box 68760, Division of Vital The law requires that the death certificete be executed

certificate

this

Hoepital or Attending Physicien:

death.

hours after deat unerai Director:

Manyland

or 28a-f ehow

Medical o the

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Spark ms

May 1, 2008

Su

32 s Signature Registra

MAY 0 4 2005

			1 - For State Registrar	State of Ma	aryland	-	artment rtificate			and M	lental Hy	giene Reg. No.	2005	-	005
			1. Decedent's Name (First, Middle, Las	t)					-		2. Date of De	ath		3. Time o	of Death
	Physici /Medic		Sophia Weint	reva							April	30	200S	350	A M
	Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	of Death	Y		County of Death	1	
			Northwest ito	spital cov	110		Ra	nda	listor	V			Baltimo	ve.	
	Funeral		5. Social Security Number 6. Se	7. Age		ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi (Month, D	rth	9. Birth	place (State intry)	or Foreign
	Director		219-20-6722	□M 2 X F	94	Yrs.	Months	Days	Hours	Min.	08/02/	1910	Col	RUSS	AIA
	p ,		Usual Residence of Decedent												
	arylar show	_	10a. Slate 10b. County			, Town or Lo								10d. Inside C	
	Ba-1:	cto	MD BALTIMO	RE	BA	LTIMOR	RE						1 ☐ Yes 2 No		
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number				10f. Zip					10g. Citiz	en of Whal Cou	intry?	
	ath w	rai	16 OLD COURT ROAD					208					U.S.A.		
	ar de	Funerai	11. Marital Status	12. Was Decedent 8 Armed Forces?		S. 13. \	Nas Deced f Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	o- 1	 Race - American Indian, Black, White, etc. 		
20	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♠ N If Yes, Give	40		1 □ Yes 2	No 🖾	Specify:				Specify: WHITE		
2-003e	within 72 hours after death with the Marylan ena. Itan "natural", or Itama 23a or 28a-1 show Ita Medical Ezamithar muhi be mulified at			Year or Dates:	1	16a Dasse	danta tiava	100000				1 101 16			
ဂ		Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	ient's Usua kind of wor DO NOT us	k done d	turina most	t of worki	ng	16b. Kin	d of Business/l	ndustry	
7	E 5 € ₹	Ë	Elementary/Secondary (0-12)	College (1-4or 5	i+)		RIETOR		,			CDU	CERY ST	∩DE	
0	I Hygin other ent,		17. Father's Name (First, Middle, Last)		J-	1 1011	VI L I OI		18. Mothe	r's Name	(First, Middle			UKL	
	o d ta b	To Be	ZALMAN		R	AUMEL			PEA		, ,	ZWI			
5	should nd Men marke imaric	Ĕ	19a. Informant's Name/Relationship (7	vpe. Print)		100	n Address	(Street a			I Route Numb		Town, State, Z	n Code)	
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		RONA BAUM / DAUGH				GLYNO						MD 2113		
a)	s 1 and 2 shou f Health and M Item 27 Is mar other traumat		20a. Method of Disposition	ILK	20b. Pla	ace of Dispo	sition (Nam	e of	- T		ate		ation - City or T		
ᅙ	Pages ment of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐		Ce	metery, crer	natory or ot	her place		- /00	/000F				
altimor	it. P		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 		ANSI	HE NEI	-						DALE, MI		
n n	permit. Departir Importa any inju		21. Signature of Purietal Service Cicen	7		22	. Name and	Addres	S OF FACILITY	y SOL	LEVIN	SON &	BROS.,	INC.	
_		-	23a. Part1. Enter the disease, or comp	lications that caused	the death								VILLE,	MD 212 Approxima	
	Physician /Medical Examiner		shock, or heart failure. List only in Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Acu Due lo (or as a	a consequ		dial	in	farc	tian				Interval Be Onset and	tween Death
8/00/	icate be exacutad physician and s the burial-transit	ai Examiner	causé Enter Underlyin. Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):												
	physics the l	dicai		d.									-		
C. Box	death certii e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month D			,	Year
7.	requiras that the ean signed by the hould ba detache		Part II. Other significant conditions of	ontributing to death bu	ut not resu	Iting in the w	nderlying ca	use aive	n in Part I		23a. Did	obacco us	e contribute to	the cause of	death?
ecords,	sign sign d ba	d by	Lacticacidos				,	g				Yes 2			Unknown
Ö	requ	ete													
Ì	Tha lay ate has page 2	Completed	Acute renal for	ailure									24b. Were aut prior to co death?	ompletion of o	available cause of
VItal	sician: certific irector.	Be	25. Was case referred to medical examiner?	Hospital:				- 01			(Check only				
5	hys this al dii	10	1 ☐ Yes 2 ☑ No	1 Minpatie	-	ER/Outpatien		-	4 🗀 1901				Other (Speci	fy)	
	Jing After fune	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	M 28	Bc. Injury Work	?		28d. Describe	how injury	occurred		
DIVISION	al or Attending F s after death. Il Director: After id in by the funeri	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined		ury - At hor	me, farm, str			res 2□h		28f. Location /	Street and	Number or Rui	al Route Nun	nber.
5	ours after ours after eral Dire	Certi	4 Homicide	building, etc	c. (Specity))	,				City or To	wn, State)			
	24 h 24 h Fur etely	edicai (29a. Certifier 1 Certifying Phyone) 2 Medicel Exem	ysician: To the best of the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a	and due to the ad at the time,	cause(s) a date and	and manner as place, and due	stated. the cause(s)
	To the within To the Complete	ž	29b. Signature and title of certifier				29c.	License	number			29d. Dale	signed (Month	Day, Year)	
			Marxian	rejiam.	D							April	30,	2005	
	10		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type,	Print) M	lan	101 - M	eila					
	4		30. Name and address of person who of S401 Old COUNT 31. Date filed (Month, Day, Year)	road R	ande	allsto	Wh	elon	You	di	21133				
ı	Sta Registr		31. Date filed (Month, Day, Year)	2005 Regular	ar's Signati	шгө	4		7						

s 23e or 28e-f show must be redilized at the redilized at	5. Social Security Number 6. Se	ley street and number) are Center ix ☐ M 2XF 7. Age (in 88	yrs. last birthday) Yrs.	Gaithe		2. Date of De Month April	ath Day 30,	Year 2005	3, Time of 8:50	and and		
Examiner Funeral Director	Wilson Health C 5. Social Security Number 218-03-4524 Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer	are Center X	• • • • • • • • • • • • • • • • • • • •	Gaithe		h	40 COU			P^{M}		
Director	218-03-4524 1	□ M 2 元 F 88	• • • • • • • • • • • • • • • • • • • •	Wilson Health Care Center Gaithersburg								
2 1 ⊱	10a. State 10b. County Maryland Montgomer			Months Days	Hours Min.		y, Year) 9, 1916	9. Birthol Coun Mary1		or Foreig		
glene. It a Medical Examinational be red Completed by Funeral Direc	10e. Street and Number	У	City, Town or Lo				·	10	0d. Inside C 1 X Yes	•		
glene. I're Medical Examination Completed by Funer	301 Russell Avenue			10f. Zip Code 20877		τ		of What Coun				
giene. Tre Medical	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S In, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)		Race - America Black, White, e Bcify White	etc.			
	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life. Teach	dent's Usual Occup h kind of work done of DO NOT use retired 1er	ation during most of world)		Montgo	mery C	y County			
Mental Hy arked othe stic evant. To Be C	17. Father's Name (First, Middle, Last) John Thomas Moore					me (First, Middle,		name)				
arin ario a	19a. Informant's Name/Relationship (7) Wendy W. Showers/			ng Address <i>(Str</i> eet a								
nent of He int: If itam iry or oth	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		osition (Name of matory or other plac ove Cemetery	May	Date 5, 2005		on - City or To				
Departn Imports any inju	21. Signal, re of Funeral Service Licens		101356 Ro	2. Name and Addres ockville, ockville,	inc. 300	bert A. West M	Pumphr ontgom	ey Fun ery Ave	eral l	Home		
ysician Medical	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the	death. Do not ent						Approximat Interval Bet Onset and I	ween		
hysician a the burial-l	if any, leading to immediate cause. Enter of identifying	b. Chronic Ob Due to (or as a cor C. Respirator Due to (or as a cor d.	sequence of):		isease							
ed by the attending p detached for use as detached for use as Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (<i>specify</i>)				Date of deliver Month		Year		
b ed be d	Part II. Other significant conditions co	entributing to death but no	t resulting in the u	inderlying cause give	en in Part I.			ontribute to the				
page 2						24a. Was autop perfo 1 \(\text{Yes} \)		b. Were autop prior to com death? 1 Yes	pletion of ca	available ause of		
To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	f 28c. Injury Work	ər: 4 🗴 Nursing H	ath (Check only o ome 5 ☐ Resid 28d. Describe h	dence 6 🗆 0)			
al Diractor: After led in by the funeral	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str pecity)			28f. Location (S City or Tou	Street and Nu n, State)	mber or Rural	Route Num	ber,		
he Funer pletely fill edical	29a. Certifier 1	vsicien: To the best of my iner: On the basis of exam and manner stated.	knowledge, death mination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the or rred at the time,	cause(s) and date and plac	manner as sta e, and due to	ited. the cause(s)		
1	29b. Signature and title of certifier Mergy	/emu	y Ma	29c. License D357			29d. Date sig May 2,	ned (Month, D	ay, Year)			
	30. Name and address of person who commerlyn K. Vermur 31. Date filed (Month, Day, Year)	1/		Print) ia Avenue	, #227,	Silver S	pring,	Mary1	and 20	0902		

DHMH 17 Rev 1/2001

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Directo

Funeral

Completed by

Be

Funeral

Director

with the Maryland

parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Musical Expiration into the Indifficulations.

Baltimore, Maryland 21215-0036

4(30/05)

Box 68760

Ö

Records,

Vital

of

or Attending

after death Diractor:

within 24 hours a

Examiner Completed by Physician/Medical Be Medical Certification: To

25. Was case referred to medical examiner? 27. Manner of Death

IF FEMALE: 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☑ No

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 T Homicide

29b. Signature and title of certifier

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

28a. Date of Injury (Month, Day Year)

MO

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an performed 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 125 PICe 28c. Injury at Work?

26. Place of Death (Check only one)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0061199

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Black 6601 31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

32. Registrar's Signature

North Charles ST Touson MD 21204

State Registrar

			1 = For State Registrar	State of I	Maryland		artmen tificate			and M		Reg. No.	53 C	THE GE	15000
	Physici	an	Decedent's Name (First, Middle,	Last)							2. Date of De Month	Day			3. Time of Death
	/Medic	al	Philip Cran				41-02-3	-	1		May 1,				7:30 p M
	Examin	er	4a. Facility Name (If not institution,				* .		Location o				County of De		
	Funeval		Holy Cross Reha		n Cente Age (In yrs. Ia		If Under	1 Year	Spr		8. Date of Birt		Montgo		e (State or Foreign
	Funeral Director		337-18-7382	1 ∑X M 2□F	80	Yrs.	Months	Days	Hours	Min.	Nov. 2	y, Year)		Country)	go, ILL
	P .		Usual Residence of Decedent		140 00										
	arylar show	_	10a. State 10b. County			, Town or Lo								i	Inside City Limits
	he M	Director	MD Mont	gomery	Wh	neaton		0-4-				10- 00			1 Tyes 2 No
	with						10f. Zip	0902				_	izen of What nited		
	ns 23	Funeral	2011 Windham I	12. Was Decede	ent Ever in U.S	S. 13. V				gin? (Spe	cify Yes or No		14. Race - Ar		
9	ours after death with the Marylan el', or Items 23e or 28e-f show Examiner mast be notified at		1 Never Married 2 Marrie	Armed Force		2				i, Puerto F	cify Yes or No Rican, etc.)		Black, W		
Maryland 21215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Jical Examination at the notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1□ Yes 2	2 L4¥N0	Specify:				Specify:	whi	.te
5	72 hours "naturel", vical Ex	Completed	15. Decedent's (Specify only highest			16a. Deced (Give	kind of wor	k done a	lurina most	t of workin	ng	16b. Ki	nd of Busines	ss/Indus	try
121	f within 7; plene. r then "n	mp	Elementary/Secondary (0-12)	College (1-4	or 5+)		oo NOTus stems					Go	overnm	ent	
d 2	Hyg the		17. Father's Name (First, Middle, L	ast)		Бу	scems	Alla	-	r's Name	(First, Middle,				
an	d a b e	To Be	Philip H. Webe	r							owers V				
ary		-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address	(Street a			Route Number			, Zip Co	de)
	1 and 2 Health a tem 27 Is		M.A. Sally Webe	r/Daughter	r	6905	Pop1	ar A	venue	, Ta	koma Pa	ark,	MD 209	912	
ore	gas 1 and t of Healt if item 2: or other		20a. Method of Disposition 1 Burial 2 □ Cremation	3 DRemoval from St	20b. Pla	ace of Dispo metery, crer	sition (Nam	ne of ther place	9)	D	ate	20c. Lo	cation - City	or Town,	, State
Ĕ	Pagas ment of l		'4 Donation 5 Other (Sp	∍cify)	Ga	te of				5/4	/05	Sil	lver S _l	orin	g, MD
Baltimore,	permit. Pag Department Importent: l eny injury c		21. Signature of Funeral Service L	gonsoo unam	_ M003	Ra	Name and app Fi 33 Gis	uner	al an	d Cr	emation ver Spr	Sei	rvices MD 20	0910	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cau nly one cause on eac	ised the death. th line.	. Do not ent	er the mode	e of dying	g, such as	cardiac or	r respiratory ar	rest,		1nt	oproximate terval Between
	Priysician	1.0	Immediate Cause (Final disease or condition	Pneu	ımonia									Or	nset and Death
	/Medical Examiner		resulting in death)	_	as a consequ	ence of):									
		5	Sequentially list conditions,	D	entia as a conseque	ence of):									
	uted 1 ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, clissace or hijary that initiated events	Corc	onary A		Disea	ise							
ó	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the buriat-transit		resulting in death) Last	0.	as a consequ									1	
8760,	cate be physicia the bur	Physiclan/Medical		d											
9	ing ph	Med	IF FEMALE:												
Вох	eath certific attending p	lan/l	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal	death 3 ☐	Ectopic pr					2	23d. Date of o	lelivery Day	y Year
0.	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnan 9⊟Unknow	nt at time of dea n	ath 5∟	Other (sp	ecify)							,
Q _	that the by detar		Part II. Other significant condition	s contributing to deal	th but not resul	Iting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco u	se contribute	to the c	ause of death?
ds,	uires sign ld be	d by									101	/es 2[]No 3□	Probably	y 4 Q Unknown
00	law raquir as bean si 2 should	lete									24a. Was	an	24b. Were	autopsy	findings available
Vital Record	9 2 9	Completed									autop perfo	med? 2 □ √ No	prior to death	?	etion of cause of
ita	(G) r-T	BeC	25. Was case referred to medical						26. Place	of Death	(Check on ty-o		101		3110
of V	S S	2	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp	oatient 2 🗆 E	ER/Outpatien	t 3 DO	A Othe	n _{Vez} -Nu	rsing Hom	ne 5 🗆 Resid	dence 6	6 □Other (Sp	pecify)	
	ing Pt	on:	27. Manner of Death 1	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Bc. Injury Work	:7		8d. Describe h	now injur	y occurred		
isio	Attending r death. ector: After by the fune	icat	2 Accident investigation of Could not be cou	ot he	Claires At hor	for at-	M	-	/es 2 □ l		8f. Location (5	Stroot an	d Alumbas as	Dura I Da	nuto Alexante est
Division	in Pite	Certification;	4 ☐ Homicide determin	ed 286. Place of building	f Injury - At hor , etc. <i>(Specify)</i>	ne, rarm, str	eet, factory	, onice		-	City or Tox			nurai no	oute Number,
	Hospit 4 hour Funer ely fille	edical C	29a. Certifier 1X Certifying (Check only one)	Physician: To the be xaminer: On the basi and manner	est of my know is of examinati	vledge, death on and/or inv	occurred a	at the tim in my op	e, date and pinion, deal	d place, a th occurre	nd due to the o	cause(s) date and	and manner place, and d	as stated	d. e cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	A A	/		29c	. License	number			29d. Dat	e signed (Mo	nth, Day	/, Year)
	(^) Cl. 1.	/ /	.0,	and		D52	261			Ma	y 2, 2	005	
1	4//		30. Name and address of person w	no completed cause	f death (Item	23а) (Туре,	Print)								
_ (ייי י		Alan R. Sega	L, MD 15	17 Hugo	o Circ	le Si	1 te	Spri	ing,	MD 20	906			
	Sta Registi		31. Date filed (Month, Day, Year)	/ 0 4 200500	gistr A Signat	المركز ولا	Jag-								

			State of Maryland / De				2005	15099
No.	· the	7	1 - State Registrar4-20-05 Amend# 1.4a.b.c.PerPhys.PCC 1. Decedent's Name (First, Middle, Last) Kimberly Bro			Reg. . Date of Death		3. Time of Death
	Physicia /Medic		KIMBERLY RIMBELLY BLOW			Month	Day Year	7:15 AM
	Examin		4a. Facility Name (If not institution, give street and number) 3270 Christines Way	4b. City, Town, or Hunt	Location of Death		4c. County of Dea	rt
*	Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F 37 Age (In yrs. last birtho	Months Days	Hours Min	Date of Birth (Month, Day, You Dec. 16,	ear) _ C	thplace (State or Foreign puntry) b., D.C.
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	or Location				10d. Inside City Limits
	eath with the Marylan ns 23c or 28a-f show must be notified at	tor	MD Calvert Hunt	ingtown				1 XYes 2 No
	th the	Director	10e. Street and Number	10f. Zip Code		10g	. Citizen of What C	ountry?
	ath w	rail	3270 Christines Way	2063			USA	
21215-0036	4 within 72 hours after death with the Maryland Jione. r then "natural", or Itams 23s or 28s-f show Ite Modical Examinal must be notilled at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 No	ispanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whi	te, etc.
2-0	72 ho	ompieted	(Specify only highest grade completed) (G	ecedent's Usual Occupa Give kind of work done d	during most of working	16	b. Kind of Business	Andustry
121	within lene. than "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired, Manager)		Restauran	+
d 2	filed Hyg the ant,	C	17. Father's Name (First, Middle, Last)	Hallager	18. Mother's Name (
Maryland	od ta b	To B	Guy R. Brock		Sandra I	. Mates		
lary	and and is rr		1.11	Mailing Address (Street a				Zip Code)
	1 and 2 Health Iam 27 othar tra			O Christine Disposition (Name of	es Way Hur	ntingtow		.0639
altimore,		1 7	1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery,	crematory or other place	θ)		c. Location - City or	
Itin			' 4 □ Donation 5 □ Other (Specify) Metropo	litan Crema 22. Name and Addres		ll Funer		1, VA.
Ba	permit. Departr Imports any inj		100 111	6512 NW Cra	Deal		MD. 20715	
	- × -		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying	g, such as cardiac or r	espiratory arrest	,	Approximate Interval Between
102	Pnysician	(1)	Immediate Cause (Final disease or condition	MEAST CAN	Cler			Onset and Death
H	/Medical Examiner		resulting in death) Due to (or as a consequence of)					
l.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	:				
	od ansit	Examin	cause. Enter Underlying Lause (Disease or injury that initiated events c.					
0,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of).	:				
8760,	ate hy:	dicai	d					
9	eath certific attending p I for use as I	a)	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of de	liven
Вох	death a atten d for u	hysician/M	250. Was deceded pregnant in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
0.	t the de by the d	hysi	9 Unknown					
S, P	es thai igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause give	en in Part I.			the cause of death?
ord	requir	eted	PHEUMONIA			1 🗆 Yes	2 M NO 3 1 P	robably 4 Unknown
Il Records,	The law requires that the death certific tate has been signed by the attending p page 2 should be detached for use as	Completed				24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Othe	26. Place of Death (
of		To :t	27. Manner of Death 28a, Date of Injury 28b. Tim	ne of 28c. Injury		5 ⋈ Residenc d. Describe how		cify)
ion	utending I death. ctor: After y the funer	atior	1 X Natural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation	ıry Work	<br Yes 2□No			
Division	or A	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28	f. Location (Stree City or Town, S	at and Number or Ri State)	ural Route Number,
	- W - O	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the basis of examination and/of and manner stated.					
	To tha within 2 To tha complet	ž	29b. Signature and title of certifier	29c. License			Date signed (Mont	
			Doman 1-felill MD. Ph.O.	D 006	2017	APO	٢١٢, 18, 20	x25
K	(20)		30. Name and address of person who completed cause of death (Item 23a) (Ty MARC HALUSHKA CACNEGIE 469E, Go		NEGT BALTH	none, MD	21287	
0	Sta Registr		APR 2 0 2005 APR 2 0 2005 Registrar's Signature-	ad				

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and Certificate of Death	d Mental Hy	ygiene Reg. No: 005	15100
g.		1. Decedent's Name (First, Middle, Last)	2. Date of D		3. Time of Death
Physic /Medi		Ademola Albert Aiyegoro	7	14 03	- OHOSAMM
Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath	4c. County of De	eath
		University Specialist Hospital Baltimore City 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 H	dre O Data at D	int 0.5	Sixtual Chata on Foreign
Funeral			lin. 8. Date of B (Month, D	Day, Year)	Birthplace (State or Foreign Country) PCTIA
Director		Usual Residence of Decedent	QCL. 11	, 1992 NI	ger ra
yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
e Ma	ctoi	MD Prince George's Bowie			1-EYes 2 No
ith th	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
ath w	ra	4502 Valiant Trace 20720	/o // /	United States	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Everth entirest entitled and ponce.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Yes 2 ⅓ No 1 □ Yes 2 ⅙ No	(Specify Yes or N Jerto Rican, etc.)	Black, W	merican Indian, hite, etc.
rs aft	by F	3 □ Widowed 4 □ Divorced Year or Dates:		Specify: B	lack American
2 hours aturel', c	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busine	
hin 7:	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of wife. DO NOT use retired)	working		
d wit	Son	5+ Professor		Education	
al Hy d oth	Be (Name (First, Middl	le, Maiden Sumame)	
Ment Ment arka	P		'. Olatunji		
2 sh and Is m	4 13	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Caniat Adeola Aiyegoro/ Wife 4502 Valiant Trace Bo		-	o, Zip Code)
T and Health			wie, MD 201	/2U 20c. Location - City	or Town State
in ite		1 Burial 2 ☐ Cremation 3 ☐ Removal from State			
Definit. Pagas Department of Mportant: If if any injury or o		'4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 4/30 21. Signature of Funeral Service Means and Address of Facility 22. Name and Address of Facility	0/2005 Fort Lines	Brentwood, N	
Deparemil Deparemin Depare		3411 Bladershure Rea			ne
1000		23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as card			Approximate Interval Between
Di di di		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1		Onset and Death
Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	Jeazo	2	And .
Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			424
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	200		1.2
cuted nd ransit	Examine	riany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Anotic encophalof	wat hy		yn.
e exe ian ar urial-t	EX	resulting in death) Last Due to (or as a consequence of):	,		
ficate be executed physician and as the burial-transit	dical	d			
the death certificate be executed the attending physician and tched for use as the buriat-transit	Med	IF FEMALE:			
ath cer attendir	cian/Me	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		23d. Date of o	Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
hat hat deta	Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	I tobacco use contribute	to the cause of death?
law requiras that as been signad b	d by		10]Yes 2 □ No 3 □	Probably 4_Unknown
Shou shou	ompleted		24a. Wa	s an 24b. Were	autopsy findings available
The law sate has b page 2 st	mc		- aut	opsy prior t formed? death	o completion of cause of ?
VICAL DEC VICIAN: The lav Certificate has rector, page 2	CO	25. Was case referred to medical 26 Place of D	1 ☐ Yes Death (Check only		es 2 No
S S :=	OB	examiner? Hospital: Other		sidence 6 Other (Si	pecify)
	lon: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurred	
Attending r death. sctor: After by the fune	atlo	1 ☑Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
	ertificat	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or own, State)	Rural Route Number,
To the Hospitel or Attendi within 24 hours after death. To tha Funerel Director: A completely filled in by the fi	0			,	
Hospi 4 hour runer	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or			
To the H within 24 To tha F complete	Medi	one) and manner stated.		20d Data singed (Ma	nth Day Vand
To To con	2	29b. Signature and title of certifier 29c. License number 7 24 97	14	29d. Date signed (Mo	9th 2005
To	1	1 Theurains	7	LIBYII ,	
e (3)		296. Signature and title of certifier Problem MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARU MEHTA, MD, 611, South charles	street	1, Rattom	ON MD21230
St Regis	tate trar	APR 2 1 2005 APR 2 1 2005 APR 2 1 2005			

			For State Registrar	State of M	l arylan		artment of I				jiene () ()5	15101
			Decedent's Name (First, Middle,	Last)						2. Date of Dea	th		3. Time of Death
	Physici /Medio		Mary Ames Alfr	riend						Apr.	15,	2005	4:30 p ^M
	Examir		4a. Facility Name (If not institution,	give street and number	7)		4b. City, Town, o	or Location	of Death	<u> </u>	4c. Count	y of Death	-
			Genesis Spa Cr					Annap				Arur	
	Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 🙀 F	ge (In yrs 73	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Count	lace (State or Foreign try)
	Director		220-30-1448 Usual Residence of Decedent	A	/3	113.		}		Jan. 16	, 1932		MD
	show		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10	0d. Inside City Limits
	Man,	tor	MD Anne	arundel			Pa	asadei	na				1 ☐ Yes 2X No
	death with the Maryland ms 23a or 28e-f show Louat be notified at	Director	10e. Street and Number				10f. Zip Code				l0g. Citizen of	What Coun	try?
	th will		378 Dutch Ship	Road			21	122				USA	
	r deg	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?		Was Decedent of I If Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		ce - America ick, White, e	
9	hours after turel', or Ite	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	_		1 ☐ Yes 2X No	Specify.	:		Speci	_{fy:} Wh:	ite
12-003p		ed t	15. Decedent's		•	16a. Dece	dent's Usual Occu	nation			16b. Kind of B	Susiness/Ind	lustry
Ç	within 72 ene. than na	Completed	(Specify only highest	grade completed) College (1-4or	. 5 . \	(Give	kind of work done DO NOT use retire	during mos	st of work	ting			Jony
7	d with	E O	Elementary/Secondary (0-12)	College (1-40)	3+)		Homer	naker			Но	ome	
<u> </u>	e filed v al Hygie I other t vent, II	Bec	17. Father's Name (First, Middle, L	ast)				18. Moth	er's Nam	e (First, Middle,	Maiden Suma	me)	
/lan		10	F. Nelson Bolt	on.				Maı	ry Th	nompson			
Mar	d 2 should be filed with and Mental Hygie 7 is marked other treumetic event, II.		19a. Informant's Name/Relationsh			N .	ng Address (Street	and Numb	er or Rur	al Route Numbe	r, City or Town	, State, Zip	Code)
•	P = C 1		Theodoric B. A	lfriend/Hus			Dutch Sh	nip Ro				21122	
Baltimore			20a. Method of Disposition 1 Durial 2 Commation	3 Removal from State	م ا د	emetery, crei	sition (Name of matory or other pla	ce)		Date 18.	20c. Location		
Ξ	tmen tent:		` 4 ☐ Donation 5 ☐ Other (Sp		146		rematory	1	[. 18, 2005	Baltin		
g	permit. Pages Department of H Importent: If ite any injury or of once.		21. Signature of Fineral Service L	densee /		22	Barranco 495 Gov.	ss of Facili & Sor Ritch	ns, I nie F	P.A. Sev Wy, Sev	erna Pa erna Pa	erk Fu	neral Home D 21146
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that cause only one cause on each	ed the deat	h. Do not ent	er the mode of dyi	ng, such as	cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	C	rovae	a lux	Acus	, ,					Onset and Death
	/Medical		resulting in death)	Due to (or a	-	uence of):	77	- UNA					
	Examiner	_	Sequentially list conditions,	b									
	pe jis	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s d conseq	uelica Oi).							
	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	uence of):	nce of):					_		
8/60,	icate be executed physician and s the burial-transit			d									
28	ficate phys	edical		d.							0		
ŏ	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Da	ate of delive	ry
ň	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant			⊒Ectopic pregnanc] Other (s <i>pecify)</i> _	у			M	onth	Day Year
J O	t the by the	hys	9 □ Unknown	9□ Unknown									
_	The law requires that the de ite has been signed by the bage 2 should be detached	by P	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause gr	ven in Part	l.	23e. Did to	bacco use con	tribute to the	e cause of death?
Ö	en si	pel	Perphral Uss	weer Clise	Me	Dea	efeter !	ucce	2_	1 □ Y	es 2 No	3 Proba	ably 4 Munknown
ecords	a SS	Completed								24a. Was a autop	n 24b.	Were autop	osy findings available inpletion of cause of
r		ρÖ								perfor	med?	death?	2 ∑ No
Vitai	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	CALL THE STATE OF			- 1000		e of Deat	h (Check only or	10)		
0	Physic this c	은	1 ☐ Yes 2 💢 No	Hospital:		ER/Outpatier	IL 3L DOA	and the second	ursing Ho	ome 5 Resid)
	ding F. h. After funera	ion	27. Manner of Death 1 SNatural 5 ☐ Pending		lury lay Year)	28b. Time o Injury	Wo	rk?) Ala	28d. Describe h	ow injury occu-	rred	
<u>s</u>	death. ctor: A the fu	cat	2 Accident investigation in Accident in Accident investigation in Accident in Ac	ot be 390 Place of It	niuny - At he	ome form et	M 1 [Yes 2□	INO	28f. Location (S	treet and Num	her or Rural	I Route Number
Division	after Direction by	Certification:	4 Homicide determin	building,	etc. (Specif	y)	eet, ractory, office			City or Tow		Der Or Hurar	noute realiber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1'☑' Certifying	Physician: To the bes	at of my kno	wledge, deat	h occurred at the ti	me, date ar	nd place,	and due to the o	ause(s) and m	anner as sta	ated.
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical E	xaminer: On the basis and manner s	of examina	ition and/or in	vestigation, in my	opinion, dea	ath occur	red at the time, o	late and place,	and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licen:	se nu <i>m</i> ber	-	2	9d. Date signe	ed (Month, E	Day, Year)
			1 The Man	MD			D3	895	8	4	4/17/	05	
			30. Name and address of person w	no completed cause of	death (Item		4 /	/	1	/	/	/	
			Daljeet Sy	gh Filly	MI		Annupo	lu 1	Roal	1#106	oden	ton	MD21113
	Sta		31. Date filed (Month, Day, Year)	2005 32. Figis	trar's Signa	ature	tod -						
	Regist	rar	APR 18	TOON TO		AT A							

		For State Registrer	State of Maryland		artment of Hortificate of L			iene () ()	5 =	51()2
		1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	h Day	Year	3. Time of I	Death
Physicia /Medica		Frances Evelyn	Dudley Bussler	•					005	10:15	PM^{M}
Examine		4a. Facility Name (If not institution, gire	re street and number)		4b. City, Town, or	Location of Death		4c. County	of Death		
		22030 Society H			Leonar				Mary'		
Funeral			Sex 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Count		Foreign
Director	-	218-22-9914 Usual Residence of Decedent	76	113.			Oct. 9	, 1928	Mary	land	
land		10a. State 10b. County	10c. City, T	own or Lo	ocation				10	d. Inside City	y Limits
Mary	ţō	Virginia Essex	Tar	naha	nnock					1 ☐ Yes	2 X No
r 28e	Director	10e. Street and Number		Pana	10f. Zip Code		10	0g. Citizen of V	Vhat Count	ry?	
death with the Maryland ms 23a or 28e-f show In wall ke nuffind at		532 Ware Avenue			22560			U.S.A			
deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His	spanic Origin? (Sp. Mexican, Puerto	ecify Yes or No-	14. Rac	e - America k, White, e		
or Ita		1 ☐ Never Married 2 X Married	1 ☐ Yes 2XX No If Yes, Give		1 ☐ Yes XXNo	Specify:	1110211, 01017	Specify		rto.	
within 72 hours after ene. than "natural", or Ita	d by	3 Widowed 4 Divorced	Year or Dates:						Whi		
nat "nat	Completed	15. Decedent's E (Specify only highest gr	ducation 1 ade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	urina most of work	ing	16b. Kind of Bu	isiness/Ind	ustry	
withir sne. than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		ephone Ope			C		•	
be filed within 72 hours after death with the Marylar latal Hygiene. Additional than "natural", or Itams 23a or 28e-f show event, if a Medical Exercited for the recitive at		17. Father's Name (First, Middle, Las	t)	тет	-	18. Mother's Name	e (First, Middle, N	Commu Maiden Surnam		lons	
ould be file Mental Hy warked oth	To Be	Robert Sorrell	Dudlev. Sr.			Vadis J	Tane Cour	ctnev			
2 should be filed v and Mental Hygie Is marked other t raumatic event, II.	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a				State, Zip	Code)	
nd 2 sh alth and 27 Is n r traun		Charles Earl Bus	sler / Husband	532 1	Vare Avenu	ie Tappah	annock.	Virgin	ia 22	560	
permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce.	Ì	20a. Method of Disposition	20h Plac	e of Dispo	sition (Name of			20c. Location -			
Page lent c nt: If ry or		1 X Burial 2 ☐ Cremation 3 [3 4 ☐ Donation 5 ☐ Other (Special Control of C	IRemoval from State St.	Mary echai	natory or other place Sel Cemete	rv Mav	1. '05	Livel	v. Vi	ruinia	3
permit. Pages 1 Department of He mportant: If iten any Injury or oth	Ì	21. Signature of Funeral Service Lice		2	2. Name and Address	s of Facility Bri	nsfield				
B B E B B		Edward N. Brinsf	ield, Jr. M000		2.0. Box 2						
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	aplications that caused the death. I	Do not en	er the mode of dying	, such as cardiac	or respiratory arre	est,		Approximate Interval Betw	veen
Physician		Immediate Cause (Final disease or condition	a Breast Cance	r wii	th Metasta	eie				Onset and Di Years	eath
/Medical		resulting in death)	Due to (or as a consequen			-010					
Examiner		Sequentially list conditions,	b								
sit 8d	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ice of):							
be executed ician and burial-transit	xarr	that initiated events resulting in death) Last	c Due to (or as a consequen	ice of):							
bu bu	T T T T T T T T T T T T T T T T T T T										
The law requires that the death certificate tite has been signed by the attending physioage 2 should be detached for use as the	edical		d								
eath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					23d. Dat	e of deliver	v	
seath atter	Physician/M	in the past 12 months?	1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deatl		Ectopic pregnancy Other (specify)			Moi		,	ear
the cy the achec	hysi	9 Unknown	9□ Unknown								
w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death but not resulting	ng in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use conti	ribute to the	e cause of de	ath?
law requires t as been signe 2 should be							1 🗌 Ye	s 2 No	3 Proba	ibly 4 📉 Ur	nknown
aw re	plet						24a. Was ar		Vere autop	sy findings a	vailable
The lav ate has page 2	Completed						autops perform	ned?	leath?	No No	use or
	a	25. Was case referred to medical				26. Place of Deat					
nysic nis ce	To B	examiner? 1 🗌 Yes 2 🗶 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatie	nt 3 DOA Othe	r: 4 ☐ Nursing Ho	me 5 🗆 Reside	nce 6XXOth	er (Specify,	Siste Home	r's
ding Phy. h. After this funeral d		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time o	f 28c. Injury Work	at ?	28d. Describe ho	w injury occurr	ed	211.10	
ol or Attendir after death. I Director: Af d in by the fu	Certification;	2 Accident investigation	ho .			es 2□No					
l or Attending after death. Director: Afte	Ě	3 Suicide 6 Could not determined		, farm, st	eet, factory, office		28f. Location (Str City or Town		er or Rural	Route Numb	ier,
pitel ours are lilled i		On Continu	h iii T the best of a least	-t		,		. / >			
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier (Check only one) (Check only one)	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	age, deat and/or in	n occurred at the tim vestigation, in my op	e, date and place, inion, death occuri	and due to the ca red at the time, da	iuse(s) and ma ate and place, a	nner as sta and due to	the cause(s)	
To the within 2 To the complet	Mec	29b. Signature and life on certifier	and mainter stated.		29c. License	number	29	9d. Date signed	i (Month, E	Pay, Year)	
F \$ F 8)XX In			102	TIC		4.26		-	
		30. Name and odress if person who	completed cause of death (Item 2)	Ba) (Type	Print)	0	1	7.26	-7		
		Rajbinder S. Gi			,	Marula	nd 20626				
Sta	tę	31. Date filed (Month, Day, Year)			-	, maryid	<u> </u>				
Registra	-	APR 2 9	2005 32. Joseph Signatur	1	real						

DHMH 17 Rev 1/2001

			For State	State of Maryl	•	artment of He		, ,	OODE	15100
			Registrar Decedent's Name (First, Middle, L.)	astl	001	tincate of D	Catif	Reg. 2. Date of Death	No. U	3. Time of Death
ı	Physici	an						Month	Day Year	
	/Medic		Barbara Joanne 4a. Facility Name (If not institution, g	-		4b. City, Town, or Lo	ocation of Death	April 18	20054c. County of Death	7.33 P
	Examin	er				Silver Sr			Montgom	
	Funeral		Holy Cross Hos 5. Social Security Number 6.		yrs. last birthday)	If Under 1 Year I	f Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign
	Director		520-46-8842	1 M 2 🖫 F	62 Yrs.	Months Days	Hours Min.	(Month, Day, Ye Jan. 16.	1943 Wyo	mina
	pc ,		Usual Residence of Decedent		O: T					
	arylar	_	10a. State 10b. County	106.	. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 录No
	8a-f	Directo	Virginia Spotsy	lvania	E	Bumpass				
	with th	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cor	untry?
	hours after death with the Maryland tural; or Itema 23e or 28a-f show al Evaminar must be notified at	Funeral	2811 Amy Drive	12. Was Decedent Ever	in 11 0 12 1	2302		aib. Van ar Na	USA 14. Race - Amer	rican Indian
	Item Item	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	10.5.	Was Decedent of Hisp If Yes, specify Cuban,	Mexican, Puerto i	Rican, etc.)	Black, White	
336	urs af	by F	3 Widowed 4 Oivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	hite
ŏ	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural" or itema 23e or 28a-1 show is marked other than "natural" or itema 23e or 28a-1 show aumetic event, the Madical Examinar must be notified at		15. Decedent's		16a. Dece	dent's Usual Occupation	on	166	. Kind of Business/I	ndustry
215	hin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done dur DO NOT use retired)	ring most of workii	ng		
21.	giene giene er the	Ю	12		Ва	nk Officer			Financial	
<u> </u>	al Hy l oth	Be (17. Father's Name (First, Middle, La.	st)		-11	8. Mother's Name	(First, Middle, Maid	den Sumame)	
<u> a</u>	should be filed within 72 ind Menfal Hygiene. I merkad other than "na umetic evant, the Medic	To	Harry Leonard	Ruegge			Myrna (Geneive Ma	arr	
Maryland 21215-0036	2 sho and is ma		19a. Informant's Name/Relationship			ng Address (Street and		·		
	and ealth m 27 har tr		Cindy Jo Leonar	·		1 Amy Driv				
ore	Pages 1		20a. Method of Disposition 1 Darial 2 Cremation 3		Db. Place of Dispo cemetery, crer	natory or other place)	_	ril 19	. Location - City or	Town, State
altimore,	men fmen tant:		'4 □Donation 5 □Other (Spec	1		itan Crema				, Virginia
Bai	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumetic es once.		21. Signatu Funeral Service Lice	anvel	F 2	ancis J. C O Universi	offins F ty Blvd,	uneral Ho W, Silve	ome Inc er Spring	, MD 20901
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the o	death. Do not ent	er the mode of dying,	such as cardiac o	r respiratory arrest,		Approximate Interval Between
3	Pnysician		Immediate Cause (Final disease or condition	Sepsis						Onset and Death
	/Medical		resulting in death)	aDue to (or as a con	nsequence of):					
1	Examiner		Sequentially list conditions,	Pneumonia						10 Days
	D :	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a con	nsequence of):					
	ecute and trans	cam	Causa (Cleages or injury) that initiated events resulting in death) Last	c. Due to (or as a con	annauonna of):					
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and otge 2 should be detached for use as the burial-transif	ai E	,	Due to (or as a con	isaquarica or).					
87	physi physi the	dicai		d						
× 6	leath certifica attending pl	/Me	IF FEMALE:	23c. If yes, outcome of pre	eonancy				23d. Date of deli-	von/
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	the d y the iched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	res that the de signed by the a l be detached f	by Physician/Me	Part II. Other significant conditions	contributing to death but not	t resulting in the u	nderlying cause given	in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	w requires been sign should be	d b	Uterine Carcino	oma				1 🗆 Yes	2 No 3 □ Pro	obably 4 Unknown
ပ္ပ	s bee	ojet						24a. Was an	24b. Were au	topsy findings available
	The lav ate has page 2	Completed						autopsy performed	l? death?	ompletion of cause of
Vita		BeC	25. Was case referred to medical			2	26. Place of Death	(Check only one)		
	S D	To	examiner? 1 □ Yes 2 █ No	Hospital: 1 ☑ Inpatient	2 ER/Outpatier	nt 3 DOA Other:	4 Nursing Hor	ne 5 🗆 Residence	e 6 □Other (Spec	sity)
0	ng Ph fter th ineral		27. Manner of Death 1 ∑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	f 28c. Injury a Work?	t 2	28d. Describe how i	njury occurred	
<u>sio</u>	utending P death. ctor: After i y the funera	cati	2 Accident investigat 3 Suicide 6 Could not	he			s 2 No			
Division of	l or Attendater death Diractor:	Certification:	4 Homicide determine		At home, farm, str oecify)	reet, factory, office	2	City or Town, S	t and Number or Ru tate)	rai Houte Number,
Ш	spital or ours afte seral Dir filled in		200 Cortifier 10 Continue	Physicians To the best of mu	ksawledge deet	h	data and along 1	and due to the course	-(a) and margar 0.0	atatad
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the Funeral Director Complete	edical		Physician: To the best of my aminer: On the basis of exar and manner stated.						
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License n	number	29d.	Date signed (Month	n, Day, Year)
}	ŧ		illu v	ND.		D6	1390	4	119/05	
	10		30. Name and address of person wh	o completed cause of death	(Item 23a) (Type,	Print)			+ +	
			Charles Oh, M.I		t Glen R	oad, Silve	r Spring	, MD 2090	1	
	Sta Registi		31. Date filed (Month, Day, Year) APR 20	2005 32 Registrar's S	Signature Lo	ule				
	negisti	ell	MLU OA	LH MILLE	No. Inches					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #5 PER inf G8446905116591910 Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 April 14, **Physician** Beatrice Vivian Barnes 8:49 A. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Numb 097-14-9788 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 93 Director August 13,1911 West Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show the Madical Examiner must be notified at Maryland Montgomery Gaithersburg 1 XYes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Russell Avenue #803 20877 United States "neturel", or Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury of other treumatic event Comple Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Harvey Barnes Georgia Hammer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward W. Shirley/ Nephew 8202 Cedar Crest Court, Denton, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Geo. Wash. University Medical Center 1 Burial 2 Cremation 3 Removal from State * 4x Donation 5 ☐ Other (Specify) Washington, D.C. Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O, Box 58007 Washington, D.C. 20037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) estive CONI Pnysician Chronic ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, for y loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery atten 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

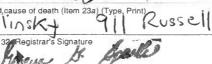
1 Yes 2 No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation er death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide afte Dir To the Hospitel o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 31. Date filed (Month, Day, Year)

Steven

29b. Signature and title of certifier

2005 20



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Gaithers b

			1 - For State Registrar	State of Marylan		artment of F ctificate of			eg. No.	5	15105
	Physici		Decedent's Name (First, Middle, Last) Ma	rgaret J. Bo	ssert			2. Date of Deat Month April		Year 05	3. Time of Death 12:52 P M
1	/Medic Examin		4e. Fecility Name (If not institution, give stre			4b. City, Town, o	r Location of Death		4c. County o		12.02 1
		•	88 Mellor Avenue			Cato	nsville		Ba1	timor	ce
	Funeral Director		5. Social Security Number 6. Sex 1 Number 1 Number 6. Sex	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 13,	Year) 1941	9. Birthpla Countr Mary	ace (State or Foreign 7) 7Land
	land bw		Usuel Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10	d. Inside City Limits
	Mary Fied	ţō	MD Baltimore	C	atonsv	ille					1 ☐ Yes 2 🗷 No
	h the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wi	nat Countr	ry?
	th wit	aiD	88 Mellor Avenue			2122	В		Unite	d Sta	ates
36	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural" or items 23a or 28a-1 show other than "natural" or items 23a or 28a-1 show event, the Mcdical Exemples in allied at	by Funeral Director	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 22 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- America , White, et	tc.
Š	2 hou	ted	15. Decedent's Educat		16a. Deced	dent's Usual Occup	ation	ina	16b. Kind of Bus		
21215-0036	l within 7 jiene. r than "n	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	Dri	DO NOT use retired	during most of work d)	ing	School	Bus	
	e filed al Hygi other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, I			
Maryland	should be nd Mental marked o	70 E	James Major				Kathleen	Norton			
Jan	and and le m		19a. Informant's Name/Relationship (Type	·	1		and Number or Run				Code)
	s 1 and of Health Item 27 other tr		James B. Bossert/H			ellor Ave sition (Name of	enue Cato		MD 2122 20c. Location - C		vn. State
nor	=		1 28urial 2 □ Cremation 3 □ Ren	noval from State	emetery, cren	natory or other plac	(e)				
Baltimore,	2 2 2 3		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Licensee	MO1 MO1		Cemeters Name and Addre			Marriott tzke's F		y FH Inc.
m	Depermine Depending Important in Sunce.		Ven Collis-	white			Columbia 1				
	Physician /Medical		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each life	upl	10000	ng, such as cardiac		est,	1	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequ	uency (f):						
		je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					-	
	cuted	Examiner	Cause (Disease or injury that initiated events c.								
8760,	icate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
387		dical	d							i	
.O. Box (that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	,		23d. Date Mont		y Day Year
s, P	8 5 8	by	Part II. Other significant conditions contri	buting to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob			cause of death?
Record	The law ate has b page 2 s	Completed						24a. Was all autops perform	y pri ned? de	or to comp ath?	sy findings available pletion of cause of
Vital	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	-10-F		Tal.	26. Place of Death	h (Check only on	e)	7.0	
of	y S	2	1 162 5 7 740		ER/Outpatien		4 🗆 Maising Ho	me 5 x Reside			
	ding h. After fune	tion		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	3	
Division	Atten ar deat ector: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str			28f. Location (St. City or Town		or Rural I	Route Number,
	Hospite 4 hours Funerel	edical C	29a. Certifier (Check only ons)	ian: To the best of my kno On the basis of examina	wledge, death	occurred at the tirvestigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and mani ate and place, an	ner as stat	ted. the cause(s)
	To the vithin 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	7 0 25	9d. Date signed ((Month, Da	ay, Year)
							141	40	April	20,	2005
			30. Name and address of person wa	er cause of death (Item	52 (Type,	Print)	*14.0	Sot	tion.	1	4071779
藻	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1				c.	V G G
	Regist	ar		Jacket Ja	100	40000					

			1- For State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death		gienè () Reg. No.	05	15106
	Dhysisi		Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Harry Marion Burns		Apri1	18	2005	10:20A [™]
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			y of Death	
			Citizens Nursing Home	Frederick	T		lerick	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 92 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da July 14	y, Year)	Cour	place (State or Foreign ntry) Ley, VA
	and w		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			1	10d. Inside City Limits
	Aaryl.	ō	MD Frederick Brunswic					12∏XYes 2 □ No
	the N	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of	What Cour	ntry?
	3a or	i Di	1100 Peach Orchard Lane	21716		USA		,
	death me 2:	era	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No	- 14. Ra	ice - Americ	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturei", or Iteme 23a or 28a-f show amy origing or other traumatic event, the Medical Evantinal must be notified at ORGE.	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 □ Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Bl	ack, White, ify: Whi	
8	ture ature	edt	15. Decedent's Education 16a, Dece	edent's Usual Occupation		16b. Kind of I	Business/In	dustry
15	n "na	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work DO NOT use retired)	ing			& Carman
212	y with	шо	Elementary/Secondary (0-12) College (1-4or 5+) 12 Burn	ns Liquors - 20 ye			Rail	
פַ	e filec othe vent,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle,	Maiden Suma	me)	
Baltimore, Maryland 21215-0036	nould be d Menta narkad natic ev	To E	Harry Austin Burns 19a, Informant's Name/Relationship (Type, Print) 19b, Mail	Helen Ga				
Ma	d 2 sh th and 7 ie r traur		1177.	ing Address (Street and Number or Rura Cool Crest Drive,				
رة _	1 and Heall em 2		20a Method of Disposition 20b. Place of Disp	osition (Name of	Date	20c. Location		
100	ages int of t: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)	/2005	Brownsv		
₫	artme ortan injur				4		TITE,	FID
	Dep Imp		Trillian Company	2 Name and Address of Facility Ohn T. Williams Fu OO Petersville Roa			MD 21	716
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition CoNCESTIVE	HEART FAIWA	u-			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	ATHERO SCIERCE	25.4			
	LXUIIIIICI	<u>.</u>		TIHERO SCORIO)2//+ ·			
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	MELLITUS				
	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):	,				
8760,	sician burit	dicai E						
687	ficate p phy: ts the	edic	d					
Вох	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7-		23d. D.	ate of delive	Эгу
	death e atte d for	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5[Ectopic pregnancy Other (specify)		М	onth	Day Year
Ö.	that the de ed by the detached	hys	9 Unknown					
S,	es tha igned be de	ру Р	Part II. Other significent conditions contributing to death but not resulting in the t	inderlying cause given in Part I.	23e. Did to	obacco use cor	tribute to th	ne cause of death?
ord	w require been si should t	ed			1 🗆 1	/es 2□No	3 🗌 Prob	ably 4 Monknown
Vital Records,	e taw re has be je 2 sho	Completed			24a. Was autop		Were auto	psy findings available mpletion of cause of
Œ		Com			perfo	rmed? 2 No	death?	a⊠No
ita	yeician: Th iis certificate director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only o	ne)		
	Phyeic this ce al dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5 🗆 Resid	tence 6 □Ot	her (Specify	y)
ב	Attending Phyeician: r death. ector: After this certific by the funeral director.	.i.o	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe h	now injury occu	rred	
sio	Attendi er death. rector: A by the fu	cati	2 Accident investigation	M 1 Yes 2 No				
Division of	or Attendated after death	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (5 City or Tox	Street and Num vn, State)	ber or Rura	il Route Number,
_	pspital hours unarai y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place,	and due to the	cause(s) and m	anner as st	ated.
	To the Hospital or A within 24 hours after To the Funaral Directomplately filled in by	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occurr	ed at the time.	date and place	and due to	the cause(s)
	5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		29b. Signature and title of certifier	29c. License number		29d. Date sign		
	6		7000	7 00 . 7 73		1- 0	, - ,	,
			30. Name and address of person who completed cause of death (Item 23a) (Type, SIBTE A KAZMI, HD 814	Print) DOO 4795 Tou House Au	E. Fr	E DERIC	K	MD 21701
	Sta		31. Date filed (Month, Day, Year) 1 2005 32. Ref. strar's Signature	Angest ;				
	Registr	ar	The state of the s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 5, 2005 Salvatore Barranca **April** 9:30 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Anne Arundel <u> Anne Arundel Medical Center</u> 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months **™** M 2□ F Yrs. Director 578-22-6919 1922 Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 28e-f show other traumatic evant, the Midical Examiner must be notified at 1 ☐ Yes 2X No Completed by Funeral Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ent: If itam 27 is marked othar than "netural", or Itams 23e or? 382 Colony Point Pl 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 TyYes 2 □ No If Yes, Give Year or Dates: WWT. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: 3 Widowed 4 Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Commercial Printer 12 Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brigida Amato Nicolo Barranca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If itam 27 is any injury or other tra once. 382 Colony Point Pl, Edgewater, ND 21037 Ida M. Barranca/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Apr 8, 2005 Silver Spring, MD Gate of Heaven Cem 21. Signature of Funeral Sarv e Livensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician Failure Morey Three /Medical Due to (or as a consequence of): reels Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown þ After this certificate has been signed in funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Levkemin 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) To the within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Kenn B Knol 000 00974H 32. Redistrar's Signature

State Registrar

		1 - For Stata Registrar	State of Marylan	d / Depa		lealth and N	Mental Hy	_	15	15110
Physic		1. Decedent's Name (First, Middle, Las.	Bauer				2. Date of Dea Month	Day	Yeer 2005	3. Time of Death 9:10 P
/Medi Exami		4a. Facility Name (If not institution, give Riderwood Villag			Sil	r Location of Death ver Sprir	ng	4c. Count	y of Death ontgom	,
Funeral Director		5. Social Security Number 6. Security Number 075–07–9233	x 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) May 18,	^h , Year) 1918	9. Birthpl Coun	ace (State or Foreigi try) NY
Maryland a-f ehow	tor	10a. State 10b. County MONTGO		y, Town or Lo		Spring			10	Od. Inside City Limits 1 ☐ Yes 2 X No
h with the 23a or 28 st Le no	Funeral Director	10e. Street and Number 3110 Gracefield	Road		10f. Zip Code 20	904		10g. Citizen of USA		try?
ified within 72 hours after death with the Maryland Hygiene. ther then "naturel", or terms 23a or 28e-f ehow int, I're Medicul Ever in set must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Ra Bla Speci	ce - America ack, White, e fy: Wh	
within 72 ho iene. then "natur	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation (a completed) College (1-4or 5+)	16a. Deced (Give life.		ation during most of work d) maker	king	16b. Kind of E	Business/Ind	lustry
d 2 should be filed within 72 hours aft and Mantal Hygiene. It is marked other then "naturel", or treumetic event, if a Mudicul Ever.	To Be C	17. Father's Name (First, Middle, Last) Ernest Downing				18. Mother's Nam Katheri	ne (First, Middle, ne Berb		me)	
es 1 an of Heal fitem 2		19a. Informant's Name/Relationship (7 Dr. Valentine Ba 20a. Method of Disposition 1 ☆Burial 2 □ Cremation 3 □	uer/Son 20b. P	1270 Place of Dispo	Fenwick sition (Name of natory or other place	Garth, A	rnold,	MD 210 20c. Location	12 - City or To	wn, State
permit. Pages 1 ar Dep rtment of Hea Importent: if item any injury or othe		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Poneral Service Licens Normal	MD	22	ans Cemet Name and Addre Barranco 195 Gov.	ss of Facility	. 19, 2005 P.A. Seve Iwy, Seve	Crowns erna Pa erna Pa		neral Home D 21146
Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line. Advance Due to (or as a consequence)	n. Do not ent	er the mode of dyin		or respiratory ar	rest,		Approximate Interval Between Onset and Death
ate be executed with the bear and was in a burial-transit and	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CLO Strice Due to (or as a consequence) Due to (or as a consequence)	duur uence of):	tract	ule u mpc	tion		3	month
the death certifica y the attending ph ched for use as th	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	Ideath 3	Ectopic pregnancy Other (specify)	,			ate of deliver	ry Day Year
quires that in signed b	by	Part II. Other significant conditions or	ntributing to death but not rest	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to			e cause of death? ably 4 □Unknown
	Completed						24a. Was autop perfor	sy	prior to con death?	psy findings available apletion of cause of
Physicien: this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inpatient 2 (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	26. Place of Dear er: 4		lence 6 🗆 Otl)
el or Attending s after death. I Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phyone 1	rsician: To the best of my kno iner: On the basis of examinar and manner stated.	wledge, death tion and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the orred at the time, or	ause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
To the within To the comp	Me		thurang	MD		9524		April	15,	2005
			HUMANA, 3110	GRA	Print) CEFIELD	ROAD, S	ILVER	SPRING	a, MD	20904
St Regist	ate trar	31. Date filed (Month, Day, Year) APR 19 2	32. Registrar's Signa	iture	Carles					

			For	State of Maryla	nd / Depa		Health and	Mental Hyg	iene	e. 5 15111	and the same of th
			Registrar			runcate or	Deaiii		g. No.		
	Physici /Medic		1. Decedent's Name (First, Middle, Las Donald Eugen	,				2. Date of Deat Month APRIL 2	8 200	3. Time of Death 3:33 A	
}	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deat	th	4c. County of	Death	
			1412 Walker	Road		Freel	and		Balti	.more	
	Funeral		5. Social Security Number 6. S		. last birthday)	If Under 1 Year		8. Date of Birth	Year) 9	. Birthplace (State or Fore	eign
	Director		215-32-3691 1. Usuel Residence of Decedent	× 2□F 70	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 21,	1934 N	Birthplace (State or Fore Country) Maryland	
	ryland how		10a. State 10b. County	i	ity, Town or Lo	ocation				10d. Inside City Lim	
:	8a-fs	Director	MD Baltim	ore F	reela					1 □ Yes 2 🔀 !	No ——
	be liled within 72 hours after death with the Maryland tall Hygiene. Add other than "natural", or Rems 23a or 28a-f show event, the Madical Examinal must be nutified at		10e. Street and Number 1412 Walker	Road		10f. Zip Code	1053	10	og. Citizen of What U.S.A	-	
	eath	Funerai	11. Marital Status	12. Was Decedent Ever in	J.S. 13.			Specify Yes or No-		American Indian,	
	r tter	돌	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	i			Specify Yes or No- to Rican, etc.)	Black,	White, etc.	
93	Exar, o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No	Specify:		Specify:	White	
2-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Usual Occup	pation during most of wo	rking	16b. Kind of Busin	ness/Industry	
2		Ig I	Elementary/Secondary (0-12)	College (1-4or 5+)					Dairy	Farm	
2	ygier ygier t, th		9		Da:	iry Far		me (First, Middle, M		raim	
Baltimore, Maryland 21215-0036	should be filed vand Mental Hygie s marked other i umatic event, it	Be	17. Father's Name (First, Middle, Last) William Orban	Baker				me (<i>First, Middle, N</i> Beatric		h	
٦	should be nd Menta marked matic ev	ဥ	19a. Informant's Name/Relationship (7		19h Maili	na Address (Street		ural Route Number,			
S	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic ev QDEs.		Ruth E. Baker	ypo, 1 1111.y				Freeland			
ē,	s 1 ar f Heal tem 2 other		20a. Method of Disposition	20b.		osition (Name of matory or other pla DWNE_		Date 3	20c. Location - Cit		
ê .	Page ento h: If y or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	Yorkto	owne Lon Serv	rice 200	ril 29,	York,	PA	
=	orta	1	21. Signature of Funeral Service Loan		2	2. Name and Addre			enstein	Mortuary, I	Inc
ä	Ped in a) XX. Xa	Menston						PA 17349	
	nysician		23a. Parh. Enler the disease, or composition, of heart failure. List only Immediate Gause (Final disease or condition	olications that caused the decone cause on each line.						Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					12010	
		- i	Sequentially list conditions,	b. Due to (or as a conse	quence of):						
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to anniholiate cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ.	e be executed /sician and e burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
		licai	(d		<u>-</u>					
89 ×	ertific ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregr	ancy				1		
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet	al death 3	☐Ectopic pregnanc☐Other (specify) _	ÿ		23d. Date o Month	•	8
o.	the deche	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	deall 5						
٥.	rhat deta	by Ph	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?	,
rds	Ine law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th							1 🗌 Ye	s 2□No 3[Probably 4 Unknow	wn
၀	awre is bee 2 sho	Completed						24a. Was ar		re autopsy findings availab r to completion of cause o	ble
ğ į	the late ha	E O						perform	ed? dea		J.
<u>ita</u>	artific ctor,	Be	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one			
<u> </u>	nysko nis ce I dire	은	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ott	her: 4 🗌 Nursing H	lome 5 Reside	nce 6 🗆 Other (Specify)	
0 0	ng Pl		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk?	28d. Describe ho	w injury occurred		
Sio	eath.	cati	Accident investigation 3 Suicide 6 Could not be]Yes 2 □No	201 11 (0)		0.10.11.1	
Division of Vital Records,	or Ar after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, sti <i>ify)</i>	reet, factory, office		City or Town,		or Rural Route Number,	
_	To the Hospital or Attending Physician: The law within 24 hours after death within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1☐ Certifying Ph	ysician: To the best of my kn	owledge, deat	h occurred at the ti	me, date and place	e, and due to the ca	use(s) and manne	er as stated.	
:	in 24 l	Medical	(Check only one) 2 Medical Exam	niner: On the basis of examin and manner stated.	ation and/or in					2 2	
	Vith To 1	Σ	29b. Signature and title of certifier	1 4.4	7	29c. Licens	se number	29	d. Date signed (A		
			20 Nama and	mb nasha	m 234 (7)	Print)	660	A	ba:15	8,2005	
	5		30. Name and address of person who	completed cause of death (Ite	m 23.1) (Type,	الم عالم	W C.T. L	thous	le Mo	, 21093	
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature	AP 0	, -	-W 101	-/ 10		
	Registr	ar	MAT 0 4 ZUU	Jelien So	· Ago						

			1 - For State Registrer	State of M	aryland / Depa <i>Cei</i>	artment of H		F	Reg. No. 0)5	15112
	Physici	an	Decedent's Name (First, Middle, L MICHAEL	·	PO	MT EC	SR.	2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, gr	R.		WLES ,		APRIL	17 2 4c. County	2005 of Death	11:30 A ^M
	Examir	ier	312 S. MAIN ST			MT. AI				ARROLL	
	Funeral		· ·	Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day	v, Year)	9. Birthpla Count	ace (State or Foreign
	Director		213-58-5502 Usual Residence of Decedent	125W 201	52 Yrs.			July 3	1952	Vir	ginia
	yland Iow		10a. State 10b. County		10c. City, Town or Lo	ocation				10	d. Inside City Limits
	a-fsh	ctor	Md. Carro	11	Mt. Air	сy					1 XYes 2 □ No
	172 hours after death with the Maryland "natural", or Items 23a or 28a-1 show officed Exercitive 18 to notified at	Director	10e. Street and Number 312 S. Main Str	eet.		10f. Zip Code	2177		10g. Citizen of		
	s 23e			12. Was Decedent	Everin II S 12	Was Decedest of H				ed St	
"	fter d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces	No i	Was Decedent of H If Yes, specify Cuba		rto Rican, etc.)	Bla	ck, White, e	tc.
03	ral', o	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Specif	y: W.	hite
21215-0036	Jwithin 72 ho piene. r than "natur tre Modical	Completed	15. Decedent's l (Specify only highest g		(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of wo	orking	16b. Kind of B	usiness/Indi	ustry
112	filed within Hygiene. other than "	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	rticultur	•		Coun	try C	lub
DQ 2	Hyg othe	Be C	17. Father's Name (First, Middle, Las	st)				me (First, Middle,			
ylaı	should be nd Mental marked o	To		wles			Doris		singer		
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship Donna M. Bowles			ng Address <i>(Street :</i> 2 S. Main				State, Zip (
	is 1 and 2 of Health a item 27 is other tree		20a. Method of Disposition	•	20b. Place of Dispo	sition (Name of		Date	20c. Location		
I O	Pages ent of mt: #Ti		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec		Montgomer	matory or other place by Method		20/05	Damasc	us, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic as once.		21. Signature of Funeral Service Lic	•		Name and Address Muriel H					-
8	89 = 8 9		Marie &	Bech	n	P. O. B	ox 5038,	Laytons	ville,		20882
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or co shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. S Q D Due to (or as	a consequence of):						Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed tee has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						_
O. Box	at the death certific by the attending p tached for use as it	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,			te of deliver onth E	y Day Year
Vital Records, P.	w requires that been signed b should be deta	by	Part II. Dther significant conditions DIABET	contributing to death to	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	_ /		e cause of death?
leco	e law requ has been je 2 shouli	Completed						24a. Was autop	sy	prior to com	sy findings available pletion of cause of
al H									2 M 6	death? 1 Yes 2	2 19 No
V:t	Physician: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	Hospital:	ent 2 ER/Outpatier	nt 3 DOA Oth		eath (Check only or	<i>ne)</i> ence 6 □Oth	or (Specify)	
ion of	ling After une	-	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of Inju (Month, Da	ury 28b. Time o	f 28c. Injun Wor	y at	28d. Describe h			
Division	tal or Attenors after death	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 200. Place of III	jury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical			of my knowledge, death of examination and/or in ated.						
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	B. Itro.	1 . Om	29c. Licens	e number	- 2	29d. Date signe	d (Month, D	2005
•	10		30. Name and address of person wh	o completed cause of a	death (Item 23a) Type,	Print) + 209	MT. A.	iny, m	0 0	47	7/
	Sta Registi		31. Date filed (Month, Day, Year)		rar's Signature	arle		*		•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 19:40 ^{p м} Kay Frances Best 16, 2005 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Feb. 6, 1 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🔀 F 1937 68 Director 248-56-2427 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ont: If item 27 is marked other then "neturel", or Items 23e or 28e-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Calvert Huntingtown 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 801 White Marsh Ct. 20639 U.S.A. Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IBMManager Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Frances Chapman John Alfred Boswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles J. Thompson 801 White Marsh Ct. Huntingtown, MD 20639 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Importent: If ite any injury or ott 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4-19-2005 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 22. Name and Address of Facility Lee Funeral Home Calvert P. 21. Signature of Funeral Service Lighnsee 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burial Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Obstructive 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 5851

31. Date filed (Month, Day

Deale

Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C SURAN A

Churchton

32. Registres Signature

50653

DEALE

4-19-2005

			, roi	artment of Health and Me rtificate of Death	ntal Hygie	ZUU5 15116
			Decedent's Name (First, Middle, Last)	2	. Date of Death Month	Day Year 3. Time of Death
J	Physici /Medic		Lisa M. Barhanovich	Z	April 17	
y	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Solomons Nursing Center	Solomons		Calvert
	Funeral Director		5. Social Security Number 578-56-5528 6. Sex 1 M 2 F 92 Yrs.	Months Dave Hours Min	Date of Birth (Month, Day, Ye May 16,	9. Birthplace (State or Foreign Country) 1912 Germany
	land land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary fed a	ğ	Maryland Calvert St. Leona	ard		1 ☐ Yes 2 ☐ No
	r 28a	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	h witi	alD	1321 Griffis Court	20685	G	ermany
36	be filed within 72 hours atter death with the Maryland hal Hygiene. od other then "natural", or Items 23a or 28a-f ehow event, the Medical Examinat must be modified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No	Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
000	hour tural'	q pa	3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	161	White b. Kind of Business/Industry
5	in 72 r "na" r	Completed	(Specify only highest grade completed) (Giv	a kind of work done during most of working DO NOT use retired)	101	b. Kind of Businessymoustry
212	filed within Hygiene. Ither then "	mo	Elementary/Secondary (0-12) College (1-4or 5+)	sewife		Homemaker
b	e filed il Hygi other vent, I	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Mai	iden Sumame)
/lar	should be and Mental marked o umatic eve		Peter Holzlhammer	Johanna Zi	ıber	
Maryland 21215-0036	s 1 and 2 should I Health and Mer item 27 le marke other traumatic			ing Address (Street and Number or Rural F Griffis Court, St.		
ē,	es 1 a of Hea fitern rothe	1 8	20a. Method of Disposition 20b. Place of Disposition competery, cre	osition (Name of Date	200	c. Location - City or Town, State
Ē	Pages nent of ant: If it ary or o		4 □ Donation 5 □ Other (Specify) Metropol:	tan Crematory 4/18/		
Baltimore,	permit. Pag Department Important: I eny injury o			2. Name and Address of Facility Raus COOMES Island Rd., I		ral Home, P.A. 4405 ublic, MD 20676
П			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or r	espiratory arrest	Interval Between
	Priysician		Immediate Cause (Final disease or condition	Lorosis		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	Lammer		Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Discass or injury)			
_	cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last			
8760,	be e	dical E				
687	ficate p physics the	edic	d			
.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Φ.	that the post of t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
rds	quires n sign uld be	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
Vital Records,	e law has b ye 2 st	Completed		"	24a. Was an autopsy performed	
Ta		0	25. Was case referred to medical	26. Place of Death (12100 2210
\	ys dir	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 42 Nursing Home	5 🗆 Residenc	e 6 Other (Specify)
n of			27. Manner of Death 128a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) Injury	of 28c. Injury at 28. Work?	d. Describe how	injury occurred
sio	Attending r death. ector: Atter	catl	2 Accident investigation	M 1 Yes 2 No	(1)	
Division	i ji te	Certification;	4 ☐ Homicide determined determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 28	City or Town, S	t and Number or Rural Route Number, State)
	To the Hospitel or within 24 hours after To the Funerel Direction completely tilled in E	edical C	29a. Certifier (Check only one) Check only one Check one Che			
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
)			Dand & Torche MD	047610	Apr	ril 18, 2005
	6		30. Name and address of person who completed cause of death (Item 23a) (Type	•		
	Sta Registi		David J. Tardio, M.D. 110 Hospital Rd 31. Date filed (Month, Day, Year) APR 1 9 2005		e rredei	TICK, MD 206/8
	5,01		TO TOO TO TOUR TO	ATTANAL		

			For Stete Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of He			giene Reg. No. 2 N	OE	Press & F. Fren
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dea	ath Day	Year	3. Time of Death 8:57 P _M
	/Medic			tha Ceceli	a Clarke			April			0:37 PM
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or Lo			4c. County o		
			18907 Point Look 5. Social Security Number 6. S		(In yrs. last birthday)	Lexington	n Park If Under 24 Hrs.	8. Date of Birt	Saint		
	Funeral Director			_M 2⊠F	83 Yrs.		Hours Min.	(Month, Day September	r, Year)		lace (State or Foreign try) y land
H			Usual Residence of Decedent					peh remoet	. 0, 1921	riai.	y Tanu
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				19	0d. Inside City Limits
	B-fs	cto	Maryland Saint Ma	ary's	Lexingto	n Park					1 ☐ Yes 2 🛱 No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Coun	try?
	23a	rai	18907 Point Lookout H			20653			USA		
	r deg	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	- 1	Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)		- Americ White, e	
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 🕅 N If Yes, Give	٥ .	1 ☐ Yes 2 ☒ No	Specify:		Specify:		
21215-0036	within 72 hours after death with the Maryland one. than "natural", or items 23a or 28a-f show then "natural" to motified at the Medical Eris cities roust be notified at	d be	3 Widowed 4 Divorced	Year or Dates:	160 Dooo	tent's Usual Occupation					
5	n 72 n "na le dic	Completed	(Specify only highest gra	ade completed)	(Give	kind of work done dur DO NOT use retired)		ng	16b. Kind of Bus	inessyind	lustry
12	withi ene. thar	шо	Elementary/Secondary (0-12)	College (1-4or 5-	+)	keeper			Media/Ne	F.10	
D	Hyg Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)	1 BOOK		8. Mother's Name	(First, Middle,	Maiden Sumame,		
lan	uld be fenta rked iic ev	To B	Claude A. Thompson				Annie Beat	rice Wib	1e		
Maryland	shound N		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and				tate, Zip	Code)
Σ	alth alth or 127 is		James Benjamin Clarke	e, Jr. / Son	P.O. B	ox 87, Great	Mills, Ma	ryland 20	0634		
ore	of He of He item		20a. Method of Disposition	30 11 0	20b. Place of Dispo		D	ate	20c. Location - C	ity or To	wn, State
Ĕ	Page nent ant: H		1 🕅 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specil		Holy Face C	emetery		ril 2005	Great Mil	ls. M	arvland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Evaniner must be multified at once.		21. Signature of Funeral Service Licer	nsee /	22 Mat	. Name and Address tingley-Gard					
<u> </u>	80 = 50		Mechael	Hardine	~ P.O	ь box 2/0, L	eonardtown	, Marylan	nd 20650		
	10 =		23a. Part1. Enter the disease, or conshock, or heart failure. List of ty	plicate ns that caused one cause on each lin	the seath Do not ente	er the mode of dying,	such as cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 5-	ne 5	er the mode of dying,	100	son.	ams		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	ena				0	fra de la constante de la cons
L	LAdiminei		Sequentially list conditions,	b							
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
_	and and il-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					_	
8760,	cate be executed obysician and the burial-transit	E E									
687	The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical		d							
Box	eath certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date	of delive	rv
	death	cia	in the past 12 months?	1□Live birth 4 4□Pregnant at		Ectopic pregnancy Other (specify)			Month		Day Year
0	that the de ed by the detached	Physician/Me	9 🗆 Unknown	9□ Unknown							
s, P	es tha igned be de	by F	Part II. Other significant conditions	contributing to death bu	t not resulting in the ut	nderlying cause given	in Part I.	23e. Did to	bacco use contrib	ute to the	e cause of death?
Z	v requir been si should I	per	_ Cm					1 □ Y	es 2□No 3	☐ Proba	ably 4 Donknown
Records,	e law r has be	pie						24a. Was a autops		ere autop	osy findings available
Œ.		Completed						perfor	med? dea	ath?	2E No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				6. Place of Death	(Check only or	18)		
	Physi this o	은	1 Yes 2 No	Hospital: 1 Inpatier			4 Nuising non)
Division of	Attending Physician: r death. ector: After this certific by the funeral director,	ion:	27 Manne eath 1 atural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury at Work?		!8d. Describe h	ow injury occurred	1	
isi	Attencer death	cat	2 Accident investigation 3 Suicide 6 Could not b		ry - At home, farm, stre		s 2□No	18f Location /S	reet and Number	or Rural	Route Number
<u>S</u>	after Direction by	Certification:	4 Homicide determined	building, etc	(Specify)	set, factory, office		City or Town	n, State)	Or Flurar	rioute ivaniber,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge, death	occurred at the time,	date and place, a	nd due to the c	ause(s) and mann	ner as sta	ited.
	To the H within 24 To the Fi	ledical	one)	niner: On the basis of and manner stat	examination and/or invited.	,		at the time, d	ate and place, an		
	To To	Σ	29b. Signature and title of entifier	-/12	reserve	29c. License n	umber	2	9d. Date signed (Month, E	Day, Year)
,			20 No.	m	ash (lases and a com		, , , ,		'/ /	-1	
			30. Name and address of person who Dr. David M. Fede				Hollywood	d, MD	20636		
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 2 7	2005 32. Sgistra	r's Signature	new					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item# 10a-1518 perMaryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician 2005 Apri1 14 8:54 A Maggie Lee Choate /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗓 F 12, 1928 Director 577-32-4066 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Expedient or untilled at MD Silver Spring Montgomery 1 (XYes 2**X**(XNo Funeral Director Washington DC 10f. Zip Code 20904 10g. Citizen of What Country? 10e. Street and Number #209 2101 Fairland Road 1101 West 20002 United States e filed within 72 hours after death val Hygiene.
other than "natural", or Itams 23a Virginia Ave., N.E Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private 8th Housekeeping 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if itam 27 is marked ofth any injury or othar traumatic avant. ODGs. 17. Father's Name (First, Middle, Last) Ruby Remy Cardiner George Rawl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Roanoke St., Hyattsville, MD Delante Rawls - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 4/23/2005 Suitland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine -transit death certificate be executed and Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical use as IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 Tyes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Diractor: After this certifics 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: $1 \square$ Inpatient $2 \square$ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3₹ DOA 2 27. Manner of Death 14 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title DO058597 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 2nd Ave. 8012 # 404 B Davar MD nano

DHMH 17 Rev 1/2001

State Registrar

yar

31. Date filed (Month, Day, Year)
APR 2 1 2005

2. Registrar's Signature

SELVER SPRING

			1 - For State Registrar	State of Maryla		artment of F			giene Reg. No. 2005	15117
Н	Physici	an	Decedent's Name (First, Middle, Las Charlotte Chase					2. Date of De Month	ath Day 2005 Year	3. Time of Death 10:15 P.M
	/Medic Examin	cal	Charlotte Chase 4a. Facility Name (If not institution, give Maplewood Health C	street and number)		4b. City, Town, o Bethesda	r Location of Death		4c. County of Dear	th
	Funeral Director		5. Social Security Number 6. Security Number 11060-07-6766		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	9. Bin y, Year) 7 26, 1917 Nev	hplace (State or Foreign buntry) V York
	be liked within 72 frouts after death with the Maryland that Hygiene Hygiene in a the institutel, or Items 23s or 28s-f show event, the Medical Examinating the invitibed at	ctor	Usuel Residence of Decedent 10a. State Maryland Montgome		ity, Town or Lo hesda	ocation				10d. Inside City Limits 1 X Yes 2 □ No
3	or 28	Dire	10e. Street and Number	P #2600		10f. Zip Code 2081	1		10g. Citizen of What Co	
	Items 238	Funeral Director	9707 Old Georgetor 11. Marital Status 1. Nover Married 35 Married	ND ROOU #2000 12. Was Decedent Ever in Armed Forces? 1 □Yes 2☑No		Was Decedent of H		pecify Yes or No o Rican, etc.)	- 14. Race - Ame Black, Whit	erican Indian, e, etc.
0000-	sturel', or	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decadent's Ed	If Yes, Give Year or Dates:	16a Dece	1 ☐ Yes 2 ☑ No dent's Usual Occup	Specify:		Specify: Wh	
61717	giene. rrthan "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired carch Ass			Mental Heal	lth Institute
ומובו	snould be file ind Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) David Zierlin				18. Mother's Nan Fannie		Maiden Sumame)	
=	d z sho th and l 7 Is ma trauma	10	19a. Informant's Name/Relationship (7 Milton Chase/ Hus	• •					er, City or Town, State, 2 Bethesda	
יע	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be inclined at ance.	1.8	20a. Method of Disposition 1 Burial 2 Cremation 3 4 One of Specify	20b.	Place of Dispo	osition (Name of matory or other place) Universers	Ce) 1 7 mg	Date ril 17	20c. Location · City or	Town, State
	Departm Departm Importar any inju		21. Signature of Funeral Service Licen	Sie Zidi	edical (2. Name and Addre	ess of Facility Co. Box 5800			rvices, Inc. 20037
F	hysician		2.3. Fert. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the decone cause on each line.		ter the mode of dyir		or respiratory a	rrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner	-a	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse						
,00/	The law requires that the death certilicale be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	icai Examiner	cause. Enter Undertying Cause (Lineass of Right) that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					
00	ng physicate as the	Medic	IF FEMALE:							
O. DOX	ne deatn certilica r the attending phy ched for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	ital death 3	□Ectopic pregnancy □ Other (specify) _	у		23d. Date of de Month	ivery Day Year
cords, r.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	enderlying cause gru	ven in Part I.		obacco use contribute to	
Leco	sician: The law red certificate has bee lirector, page 2 shou	Completed						24a. Was autop perfo	an 24b. Were at prior to death?	utopsy findings available completion of cause of
N E	ysician: The is certificate ha director, page	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea	ALC: NO PERSON		
10 110	ding Pnys h. After this (funeral dir	tion: To	1 Yes 2 No 27. Manner eath 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Inju	y at		dence 6 Other (Spe	cify)
DIVISION	after deat after deat Director: d in by the	Certificati	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, st cify)			28f. Location (a City or Tox	Street and Number or Ri wn, State)	ural Route Number,
	to the Hospitel or Attending Priysician: In the Funerel Director: After this certified completely filled in by the funeral director, it	edicai C		ysician: To the best of my k niner: On the basis of exami and manner stated.						
	vithii To th	Me	29b. Signature and title of certifier		•	29c. Licens	se number	- 0	29d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who	completed salse of death (It	em 23a) (Typa	Print) DVA	Kauen	57 M	7120	105
			30. Name and address of person who (S2 SC SC SC ST SC SC ST SC ST SC ST SC ST SC ST SC ST ST	ONSIN,	AVE	557	HESD	3, 41	2 208	14
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 0 20	324 Registrar's Sig	nature 6	estes		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:45 AM April 2005 Anna Jane Cummins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/9/26 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Yrs. Illinois 320-20-7079 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28e-f show the Medical Examiliar minust be redified at MXYes 2 □ No MD Harford Aberdeen Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21001 U.S.A. 175 Mt. Royal Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status fited within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Educator Public School othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Constance Dallis Jesse A. Duck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) oartment of Health are cortant: If Item 27 Is injury or other trace Edward Cummins 'Husband 175 Mt. Royal Ave., Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdns. 4/26/05 Bel Air, Maryland 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Jumins, Huna 23e. Did tobacco use contribute to the cause of death? ð 2 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 146 24a. Was an Rementia 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA Inpatient this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1- Natural 1 ☐ Yes 2 ☐ No Accident

Division

To the Hospital o within 24 hours aft To tha Funarel Di

State Registrar 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

çause)of death (Item 23a) (Type, Print)

6 Could not be determined

APR 2

3 Suicide

29a, Certifier

Medical

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

114 32. Reg 2005

			ricase	State of Marylan				-		gibic.	
		1	For Stata Registrar	otato or many tan		rtificate of			Rag. No. 2	005	15119
	Physicia		1. Decedent's Name (First, Middle, La.					2. Date of I		Year	3. Time of Death
	/Medic	al	ROBERT FRANKLI 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of	APRII		2005 nty of Death	1:30 P ^M
	Examin	er		GERSTOWN			RSTOW			HINGT	ON
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.			r If Under 2	24 Hrs. 8. Date of 8	Birth Dav. Year)	9. Birthp	place (State or Foreign
	Director	_	217-46-9885 Usual Residence of Decedent	56	Yrs.			August	8,1948	3 Penns	sylvania
	yland how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
	Be-f s	ector	Maryland Washing	ton H	agerst				42 000	(100)	1 ☐ Yes 2 🛣 No
	with the a or 2	Dire	10e. Street and Number 20009 Rosebank Wa	٧		10f. Zip Code	1742		10g. Citizen	of What Cour ed Stai	•
	death ms 23	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.			gin? (Specify Yes or I Puerto Rican, etc.)		Race - Americ	ean Indian,
36	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🖾 No If Yes, Give		1 Yes 2X No		, r derio rilozii, etc.,		cify: Whi	
Ö	within 72 hours after death with the Maryland ene. Then "neturel", or Items 23a or 28e-f show the Medical Ever in er mant be notified at	ed b	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual Occi	upation		18b. Kind of	f Business/Inc	dustry
215	thin 72 e. en "ne	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work don DO NOT use retir	e during most ed)	of working			
21	filed wil Hygien other th		10 17. Father's Name (First, Middle, Last	1	Mast	er Mecha		r's Name (First, Midd		obile I	Repair
Maryland 21215-0036	od tal	To Be	Virgil Collins	,				othea (und			
ary	should and Men s marke umetic	۴	19a. Informant's Name/Relationship (Туре, Print)	19b. Maili	ing Address (Stree		r or Rural Route Num			Code)
M,	1 and 2 Health a tem 27 is	3.	Michael Collins		_1			. Charles			
Jore	ages 1 nt of H : If ite		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐	THemoval from State		osition (Name of matory or other pi n Cremato		pril 20,		on - City or To	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.	ı	*4 □ Donation 5 □ Other (Special 21. Signature of Fine 13 15 10ce Lice	77	2	2. Name and Add	ress of Facility	2005			Maryland
B	Depa Impo eny ir		1/2/1		9	501 Cato	ctin M	al Service tn. Hwy. I	rederic	ot Cody	P.A. 21701
			23a. Paul. Exter the disease, or com- shock, or heart failure. List only						arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)			neve	ingan	etra			ter mia
	Examiner		f	Due to (or as a conseq	derice oi).						
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):						-7
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):					-	
760,	te be e ysician ie buriż	calE	(d							
89	leath certificate attending phys I for use as the	lb ed	IF FEMALE:								
Вох	ath ce attendi for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn: 1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	☐Ectopic pregnan☐ Other (specify)				Date of delive Month	ery Day Year
P.O.	that the de led by the a detached t	Physiclan/M	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	out of						
	es thai igned b	by P	Part II. Other significant conditions								ne cause of death?
Records,	w require been si should b	Completed	Statute Palli	is respect	men		~ ~		1		pably 4 Hnknown
Rec	The law cate has t page 2 s	mpl	oblinche in	man sine	-			pe	topsy rformed?	prior to cor death?	psy findings available mpletion of cause of
Vital	ilcien: Th certificate rector, pag	a l	25. Was case referred to medical				26. Place	of Death (Check only	2 No	1 🗆 Yes	2□ No
of V	Physicien: this certificated director, is	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2							ASSISTED
ou o	ding P h. After I funera	tlon:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	uryat ork? □Yes 2□1		e how injury occ	pernuc	
Division	or Attendate death Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	De Diese of Injust - At h	ome, farm, si	treet, factory, offic	9		(Street and Nu	mber or Aura	al Route Number,
Ö	itel or irs afte rel Dir led in										
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical		hysician: To the best of my knominer: On the basis of examination and manner stated.							
	To the vithin To the comple	Me	29b. Signature and title of certifier				nse number		29d. Date sig		
) — Tout	M.O.			3010				
	9		30. Name and address of person who	= 1 1 2 7 14	m 23a) (Type	Print)	· HA	ICERS 70	wr,	mo	21740
	Sta	ate	31. Date filed (Month Pay Ryear) 1	2005 32. Resistrar's Sign	ature	A 150					
	Regist	rar	4		All ph						

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H		Re	g. No.	05	1512
	Physici /Media		1. Decedent's Name (First, Middle, Las David Orr C	n handler				2. Date of Deat Month April	Day	Year 005	3. Time of Death 6:33A M
<i>)</i>	Examir		4a. Facility Name (If not institution, give Genesis Magnolia	Center	(la una la ad himbada u	4b. City, Town, or Lanh			4c. County Princ	e Geo	
	Funeral Director		5. Social Security Number 6. Security 11 Control of Security 11 Cont	·	(In yrs. last birthday) 77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 12	, 1927	Coun	lace (State or Foreigr try) Land
	Maryland e-f show iffled at	ctor	10a. State 10b. County Maryland Prince G		10c. City, Town or Lo	Upper Ma	rlboro			10	0d. Inside City Limits 1 X Yes 2 □ No
	h with the	ai Dire	10e. Street and Number 12905 Brooke La	ne		10f. Zip Code	772	1	0g. Citizen of V	Vhat Coun	itry?
50	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Modical Exacting transl be rightled at Ances.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 MYes 2 Mo If Yes, Give Year or Dates:	o	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - America sk, White, e	etc.
)0-CIZI	within 72 hou ane. than "nature a Medical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor)	king	16b. Kind of Bu		,
Maryland 21215-0036	uld be filed v Aental Hygie rked other t tic event, tr	To Be Co	17. Father's Name (First, Middle, Last) Dr. Douglas Robs	on Chandle		as roran		ne (First, Middle, M	Aaiden Sumam		Belli
Mary	nd 2 sho alth and h 27 is ma or trauma	1/3	19a. Informant's Name/Relationship (7 Susan G. Jenkins/		64.	ng Address <i>(Street a</i> High St.		indsor, M			Code)
more,	Pages 1 ament of Heamont: If Item		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		All Count	matory or other plac ty Cremat	ion 4/14	4/2005	Sykesv	ille.	
ŝ	permit. Depenting		21. Signature of Funeral Service Licent	1. Hars	ler :	2. Name and Addres 310 Church	St.	New Wind	sor, MI		76
\ 3\ \ 3\ 	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Acute m	the death. Do not enea. yocardial consequence of):			or respiratory arre	est,	m	Approximate Interval Between Onset and Death Inutes
2	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Diffuse	consequence of):	atherosc	lerosis				years
,097	ate be executed hysicien and the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					II	
P.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat	e of delive	ry Day Year
	uires that n signed b Id be deta	by	Part II. Dther significant conditions of Severe chron		•	, ,	en in Part I.				e cause of death? ably 4 □Unknown
Vital Records,	: The law requir cate has been si page 2 should I	Completed	Hyperlipidem	ia				24a. Was an autops perform	y p	orior to con leath?	psy findings available inpletion of cause of
of Vital	hysician: Th this certificate il director, pag	To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 No		nt 2 ☐ ER/Outpatie		er: 4 🛮 Nursing H	ath <i>(Check only one</i>	e) nce 6 🗌 Othe	er (Specity	
ivision of	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	ertification;	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 5 Pending investigation 6 Could not be determined		Year) Injury ry - At home, farm, st	M 1 🗆	/ at <br Yes 2 □ No	28f. Location (St. City or Town	reet and Numb		l Route Number,
Þ	Hospitel or 4 hours afte Funerel Dir ely filled in	ledical Cert	29a. Certifier 1 XCertifying Ph (Check only 2 Medical Exam	ysician: To the best of inner: On the basis of	f my knowledge, deat examination and/or in			o, and due to the ca	use(s) and ma		
•	To the i	Medi	one) 29b. Signature and title of certifier	and manner stat		29c. Licenso D247	a number		9d. Date signed	d (Month, L	
	M3		30. Name and address of person who a Ravinder Rustag		ath (Item 23a) (Type, 6132 Land	Print)		y, MD 20			
	St Regist		24 Data Glad (March Day Vees)	32. Registrat	de Cienetura						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	•	artment of Health a rtificate of Death		2005 1514	2 1
5	9		Registrar 1. Decedent's Name (First, Middle, Last)		uncate of Death	2. Date of Death	3. Time of De	eath
	Physici /Medic		Jakest R Ce	ole.		April 1	Day Year 7:00	рм
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death	4c. County of Death	
			16648 Trenton Road 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Upperco If Under 1 Year If Under 2	4 Hrs. 8. Date of Birth	Baltimore	(
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 F	85 Yrs.	Months Days Hours	Min. (Month, Day, Y	(ear) 9. Birthplace (State or Formula) L920 Maryland	oreign
			Usual Residence of Decedent			Joan of a		
	anylar show	ř		10c. City, Town or Lo			10d. Inside City L	
	the M	Director	Maryland Baltimore 10e. Street and Number		Uppe		. Citizen of What Country?	
	3a or		16648 Trenton Road		211		USA	
	Bms 2	Funeral	11. Marital Status 12. Was Decedent Example Forces?	ver in U.S. 13.	Was Decedent of Hispanic Orig f Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	ours after death with the Marylan ral', or Itams 23a or 28a-f show Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No	o	1 ☐ Yes 2 ☑ No Specify:	,	Specify: white	
21215-0036	be tiled within 72 hours after death with the Maryland nat Hyglene. od other then "natural", or Itams 23a or 28a-f show event, the Modified Examinational De notified at		15. Decedent's Education	16a. Decer	dent's Usual Occupation	16	6b. Kind of Business/Industry	
215	within 72 ene. then "ns he wedi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	life. I	kind of work done during most DO NOT use retired)	of working		
	e filed within al Hygiene. I other then vant, the Me	Соп	12	Tr	ruck Driver		Oil Company	
Maryland	I be fit ntal H ed ott	Be	17. Father's Name (First, Middle, Last) B. Randall Cole			's Name <i>(First, Middl</i> e, <i>Ma</i> chel Cooper	aiden Sumame)	
Ž	ss 1 and 2 should be fi of Health and Mental F item 27 is marked ot r othar traumetic evar	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number		City or Town, State, Zip Code)	
	and 2 sealth ar n 27 is		Louise H. Cole, wife		18 Trenton Road			
Baltimore,	of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	natory or other place)		Oc. Location - City or Town, State	
ţim	Pages Iment of I tant: If it		'4 □Donation 5 □ Other (Specify)			04/21/2005	Upperco, MD	
Bal	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	22	Name and Address of Facility. 934 South Mair		neral Home	
			23a. Part1. Enter the disease, or complications that caused t	he death. Do not ent			t. Approximate	
	Pnysician		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition				Interval Betwee Onset and Dea	
	/Medical		resulting in death)	consequence of):				
	Examiner	<u>_</u>	Sequentially list conditions, b. Due to (or as a	consequence of):				
	nted Insit	Examiner	cause. Enter Underlying	consequence or).				
Ć,	execu an and rial-tra	Exal	that initiated events c c Due to (or as a	consequence of):				
8760,	cate be executed physician and the burial-transit	dical	d					· · · · · ·
9	entific ding p	/Mec	IF FEMALE: 23c. If yes, outcome o	f pregnancy			204 But of the	
Вох	eath certifi attending I I for use as	clan	in the past 12 months?	Petal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Yea	ır
0	at the de by the a tached	Physiclan/Me	1 Yes 2 No 9 Unknown 9 Unknown					
S, P	s this	by P	Part II. Other significant conditions contributing to death but CHF Tinterm		ndenying cause given in Part I.		cco use contribute to the cause of deat	
Records,	w require been sig should b		CHL THEIM	Hours 121	TID	1 🗌 Yes	20 No 3 Probably 4 Unk	
3ec	e law has b	Completed	HIN			24a. Was an autopsy performe	24b. Were autopsy findings ava prior to completion of caus death?	allable se of
a		e Co	25. Was case referred to medical		OC Plane	of Death (Check only one)		
Vital	S S	0 0	examiner? Hospital:	t 2 ER/Outpatier	Other	~/	ce 6 Other (Specify)	
n of		J.iuc	27. Manner of Death 28a. Date of Injury (Month, Day	Year) 28b. Time of	28c. Injury at Work?	28d. Describe how	injury occurred	
sio	Attanding of death. Sector: After by the fune	catle	2 Accident investigation	A11 - 6 - 1	M 1 ☐ Yes 2 ☐ N		and Alicenter of Const. Control of	
Division	or Attandated death	Certification:	4 Homicide determined 286. Place of injur	y - At home, farm, str (Specify)	eet, factory, office	City or Town,	et and Number or Rural Route Number State)	Γ,
_	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only Medical Examiner: On the basis of	my knowledge, deat	n occurred at the time, date and	place, and due to the cau	se(s) and manner as stated.	
	To the Hospita within 24 hours To the Funeral completely filled	Medical	one) and manner stat	ed.				
		Σ	29b. Signature and title of certifier		29c. License number	290	1. Date signed (Month, Day, Year)	
7	MIL		leren TYLMS	ath (Itom 23a) (Time	D0021810		4/10/10	
	. φ		30. Name and address of person who completed cause of de	13 Manch	restir ld Mo	inchester in	D 21102	
•	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar	's Signature				

		1 - For State Registrar	State of M	laryland / D	epartme Certifica	ent of H	lealth a Death	ind Me		giene2 Reg. No.	005	151	22
Physicia	an	1. Decedent's Name (First, Middle, La Doris King Cole							2. Date of De. Month	ath Day	Year	3. Time of De	eath
/Medic	al	4a. Facility Name (If not institution, giv)	4h Ci	hr Town or	Location o	f Dooth	April	18	2005 unty of Death	4:30	_a [™]
Examin	er	Carroll Lutheran		Ct	-L-		inste				Carrol		
Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. last birt	hday) If Und	ler 1 Year	If Under 2		8. Date of Birt (Month, Da	h		place (State or F intry)	Foreign
Director		218-05-2520	□M 2Gx	90	rs.	Days	Tiours	- 1	Vov 28			MD	
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City	Limits
Many -feh	tor	MD Carrol	L	West	minste	r						1 Yes 2	No
th the	Director	10e. Street and Number		-	10f.	Zip Code				10g. Citizer	of What Cou	intry?	
23a ust b	ral	205 St. Mark Way					1158				SA		
er des	nne	11. Marital Status	12. Was Decedent	?	13. Was De If Yes, s	cedent of Hi becify Cuba	ispanic Orig n, Mexican,	jin? (Spec , Puerto R	cify Yes or No lican, etc.)	14.	Race - Ameri Black, White		
Ir. or	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	-	1 🗆 Yes	2 X No	Specify:			Sp	ecify: Wh	ite	
2 hou		15. Decedent's E		16a.	Decedent's U	sual Occupa	ation	- A			of Business/Ir		
ithin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of life. DO NO)))	or working	9		imore		
led w lygier lygier har th		12. Father's Name (First, Middle, Last,			Tel	ter	10 Maha	de Maria	/First Mindels		Electr	10	
d be fi) Be								(First, Middle,				
In yial In Z 12.15-0000 2 should be filed within 72 hours after death with the Maryland and Mendel Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic avant, it is Marcical Examination used to indiffed at	스	Joseph Edward Bas 19a. Informant's Name/Relationship (19b.	Mailing Addre	ss (Street a			Elizabe			o Code) 254	27
and 2. and 2. ealth ar m 27 is		Elaine C. Breiter	bach/daug									Virginia	
of He of He rothe		20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □	Demoval from State		y, crematory o	r other plac	θ)	Da			ion - City or T		
Pages ment of ant: # lt		'4 Donation 5 Other (Specif		Woodla	wn Cem	_		/21/2			more,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mariala Hygiens. Insturet, or Itams 23a or 28e-f ehow any injury or other traumatic event, Ita Marylad Examination without all once.		21. Signature of Funeral Service Licer	ISOO		Prit	and Address	is of Facility Ineral	Home	e and (Chape1	, P.A.		
		23a. Part1. Enter the disease, or com	nlications that cause	d the death. Do n	412	Washi	ngton	Road	d West	t minst	er, M	21157 Approximate	
AT COL		shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	_	ten-		1 .	ense			Interval Betwe Onset and De	en ath
Physician /Medical		disease or condition resulting in death)	α	s a consequence of		Nen		JV 1 - Z ×	OUT				
Examiner		Sequentially list conditions	b										
D ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequence o	00:								
and J-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequence o	of):						-		
icate be executed physician and sthe burial-transit	dical E		d										
ificate g phy: as the	edic		. 0.							- 10	7		
w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetel death	3 □Ectopic	огоправсу				23d	. Date of deliv		
e deat he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☒ No		at time of death	5 Other						Month	Day Yea	ar
hat the		9 ☐ Unknown Part II. Other significant conditions of	ontributing to death	but not resulting in	the underlying	T CALLED CITY	an in Part I		23a Did to	obacco use	contribute to t	he cause of dea	th?
signe d be d	d by	DW/monas-1	Inon	Diver		g cause give	arriir arci.		1 🗆 Y	<u>\</u>			
w requir been si should	Completed			1					24a. Was	-		onsy findings av	ailable
vital nor	duic								autop perfo	rmed?	death?	opsy findings ava impletion of caus	se of
an: Train	a	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o	2 No	1 🗆 Yes	2) No	
hystci hystci nis ce	To B	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpat	ent 2 ER/Out	patient 3	DOA Othe	ar: 🔏 Nur	sing Hom	e 5 🗆 Resid	lence 6	Other (Speci	fy)	
ing Pi		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, Da	ury 28b. T	ijury	28c. Injury Work	at c?	28	3d. Describe h				
ttend death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not b		iun. At homo far	M street fact		Yes 2□N	-	Rf Location /9	Street and N	umber or Que	al Route Numbe	
after Direct In by	Certification:	4 Homicide determined	building, e	ijury - At home, far itc. <i>(Specify)</i>	m, street, ract	ory, omce		20	City or Tow	m, State)	umber of hum	ar modite realition	,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death. To the Funeral Director: Attentia the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Exer	ysician: To the best niner: On the basis	of examination and	, death occurre	ed at the timon, in my or	e, date and	i place, ar	nd due to the o	cause(s) and date and pla	d manner as s	tated. o the cause(s)	
o the ithin 2 o tha o tha	Medical	29b. Signature and title of certifier	and manner s	tated.		9c. License					gned (Month,		
F 3 F 8		· alm	2000			D 5	5170	5		4	-18-	-	
MJ		30. Name and address of person who	completed cause of	death (Item 234) (Type, Print)				Do 6.	_	×0 0	1117-7	
10		m. PANSURIYA	349		n DR	r	tegr	WIL	75702	- 1	ODX	117/	
Sta Registr		31. Date filed (Month, Day, Year) APR 1 8		par's Signature	e L	Al a							

		1 - For State Registrar	State of Maryland		artment of H			giene	15	15123
Physic		1. Decedent's Name (First, Middle, Last) Charles Willia					2. Date of De Month		X oak	3. Time of Death
/Medi Examii		4a. Facility Name (If not institution, give s	t HOSPHO	1	4b. City, Town, or	Location of De	eath Md	4c. Count	y of Death	any
Funeral Director		5. Social Security Number 6. Security Number 17.	7. Age (In yrs. k	a <i>st birthd</i> ay) Yrs.	Months Days	If Under 24 H Hours M	frs. 8. Date of Bir in. (Month, Da July 2	y, Year)	9. Biltir Cor 6 M	hplace (Shate or Foreign untry) aryland
and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
a-f sho	ctor	MD Allegan	y Fro	stbur	g					1 ☐ Yes 2 ☐ No
death with the Maryland ms 23a or 28a-f show Liverity of the mailing at	Director	10e. Street and Number 101 Pearson St	reat		10f. Zip Code	2		10g. Citizen of		untry?
death ms 23	Funeral		12. Was Decedent Ever in U.S Armed Forces?		2153	ispanic Origin?	(Specify Yes or No		ce - Amer	rican Indian,
hours after ural, or ite	ğ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba I□Yes 2☐No	Specify:	White	Specia	ack, White ify: V	White
ISTYISTIC ZIZIS-UUSO 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-1 show aumatic event, the Medical Exercities are the inclined at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired abled	during most of v	working	16b. Kind of E	Business/l	industry
and A d be filed v ental Hygie ted other t	a)	17. Father's Name (First, Middle, Last)			abica	18. Mother's N	Name (First, Middle,	, Maiden Sumai	me)	
aryiar should by ind Menta in marked umatic ev	To B	Wes Crawford					a Mae (I		-	
# 4 F F		19a. Informant's Name/Relationship (Ty Sylvia Platte:								ostburg MD
DAILLIMOTE, IN permit. Pages 1 and 5 Department of Health Important: If Item 27 any injury or other tre once.		20a. Method of Disposition ↑☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Pi		sition (Name of natory or other pla		Date	20c. Location		
Salfilmor bermit. Pages Department of mportant: If it any injury or o		`4 ☐ Donation 5 ☐ Other (Specify)	Fro	-	rg Memor		pr 29 0	Fros	tbur	g_MD
Depa Impo		21. Signature of Funeral Service Licens	Koing	1:		ional	Hafer Fu Hwy., La	avale,	Ser MD	rvice PA 21502
Pnysician		23a. Part1. Enfer the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.		er the mode of dyin		Cance			Approximate Interval Between Onset and Death
/Medical Examiner		1	Due to (or as a consequ	ience of):						·
) bed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Line of Johnson Cause (Disease or injury	Due to (or as a consequ	ience of):					-	
icate be executed physician and sthe burial-transit	dical Exar	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):						
certificate oding physise as the	a)	IF FEMALE:	·							
death death e atter	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)				ate of deli	ivery Day Year
S, F.	by P	Part II. Other significant conditions con	ntributing to death but not resu	ılting in the u	nderlying cause give	en in Part I.		obacco use con Yes 2□No		the cause of death?
e law has b	ompleted							osy ormed?	prior to o death?	topsy findings available completion of cause of
ysician: Th ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of D	1 ☐ Yes Death (Check only o	20 No	1 1 1 1 1 1 1 1	2 140
Of VICA Physician: rthis certific ral director,	2	1 Yes 2 No	28a. Date of Injury	ER/Outpatien	28c, Injun	4 □ Nursing	g Home 5 Residence 28d, Describe	dence 6 🗆 Otl		rify)
nding ath. r: Afte	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No				
DIVISION OF the Hospitel or Attending Physin 24 hours after death. The Funaral Director: After this pleitely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (. City or To		ber or Rui	iral Route Number,
To tha Hospitel or within 24 hours afte To tha Funaral Dis completely filled in	edical	29a. Certifier 15 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or in	occurred at the time vestigation, in my of	ne, date and pla pinion, death o	ace, and due to the ccurred at the time,	cause(s) and m date and place,	anner as , and due	stated. to the cause(s)
To tha within 2 To tha complet	Σ	29b. Signature and title of certifier	-d		29c. License	e number	,	29d. Date signe	ed (Month	ı, Day, Year)
		30. Name and address of person who co	ompleted cause of death (Item	23а) (Туре,	Print)	ر 17.18		1/2-	105) .
3		OR, HAQ AHI 31. Date filed (Month, Day, Year)	mad 625	Ken	+ Avenu	Je, Ci	umberl	and,	mp	21502
St Regist	ate trar	MAY 0 4 2005	32. Registrar's Signal	Spark	U					

			For Stete Registrer	State of Maryla		artment of He			ene 1. No. 2005	15121
ı	Physici	an	1. Decedent's Name (First, Middle, Las	,	ID	COD		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al.	HERMAN 4a. Facility Name (If not institution, give	ARTHI street and number)	JR	COE 4b. City, Town, or L		April 2	24, 2005 4c. County of Dea	11:50A ^M
			Upper Chesapea				Bel Air			rford
	Funeral Director		5. Social Security Number 6. Sec. 218–22–2642	X 7. Age (In yrs	. last birthday) L Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day, 1 11/24/	1923 9. Bir	thplace (State or Foreign puntry) Maryland
	and w		Usuat Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryis a-f sho	tor	MD. Harf	ord		Al	perdeen			1 ☐ Yes 2 XNo
	vith the	Director	10e. Street and Number	~		10f. Zip Code	22.002	100	g. Citizen of What Co	
	ms 234	Funeral	2 East Inca	Street 12. Was Decedent Everin	J.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	21001 panic Origin? (Spec	cify Yes or No-	14. Race - Ame	
36	be filed within 72 hours after death with the Maryland ald Hygliene. Ald Hygliene do the then "naturel", or Items 23a or 28a-f show other then "naturel", or Items 23a or 28a-f show event, the Markeal Exattation into the indiffered at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates:	949	72	Specify:	sican, etc.)	Black, Whi	White
Maryland 21215-0036	72 hou nature	eted l	15. Decedent's Ed (Specify only highest grad	ucation	16a, Dece	dent's Usual Occupati	on rina most of workin	g 16	6b. Kind of Business	
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done dua DO NOT use retired) Horsen			Horse R	acinø
nd 2	outd be filed Mental Hygi arked other atic event, I	Be Co	17. Father's Name (First, Middle, Last)				8. Mother's Name			
ryla	should be filed ind Mental Hygi marked other umatic event, I	1º	Charles 19a. Informant's Name/Relationship (7	Edward	Coe	ng Address (Street an	Virgini		tledge	Tolley
	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any injury or other treumatic ones.		Diane L. Johns		1	last Inca			en, Md.	21001
altimore,	Pages 1 a nent of He nnt: If item try or othe		20a. Method of Disposition 1 ABurial 2 Cremation 3	Removal from State	cemetery, crer	sition (Name of matory or other place)		ate 20	c. Location - City or	
in i	permit. Pag Department Importent: I any injury o		* 4 ☐ Donation 5 ☐ Other (Specify)			.1 Cemete				le, Md. Maryland
 B	permit. Departr Importe any inj		111. Blesch	en with	سنست	E.G. Kur	tz & Sc	n Fune	ral Hom	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the dea ne cause on each line. a	= 8	er the mode of dying, ACTER	such as cardiac or	respiratory arres	5/5	Approximate Interval Between Onset and Death A SULLS
8760, <	cate be executed hysicien and the burial-transit	dicai Examiner	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.						
.O. Box 68	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	at death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	w requires that been signed b should be det	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause given	in Part I.	23e. Did toba	_/	o the cause of death?
		Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vital	yslcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	Other	26. Place of Death	1	ce 6 ∐Other (Spe	
n of	ng Phys fter this ineral di	on: To	27. Manner of Death 1 Production 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		t 21	3d. Describe how		City)
Division of	To the Hospitel or Attending Physicien: which 24 hours after deals as a feet deals To the Funerel Director: Atten this certifica completely filled in by the funeral director,	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Spec	nome, farm, str		s 2 No	3f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
_	To the Hospitel within 24 hours a To the Funerel I completely filled	0	(Check only 2 Medical Exem	sician: To the best of my kn iner: On the basis of examin	owledge, death	n occurred at the time, vestigation, in my opin	, date and place, ar	nd due to the caus	se(s) and manner as	stated.
	To the within 2 To the comple	Medical	29b. Signature and title of certifier	and manner stated.	- m. s	29c. License n	10 mber 3 / 7 7 5	29d	Date signed (Mont	h, Day, Year)
•	4	1	30. Nin ya address of person who o	ompleted cause of death (Ite	m 23a) (Type,	Print) 3/1/	LSTON	ARRI MARI	21.4NX	21047
ā	Sta Registr		31 Date filed (Month, Day, Year) MAY 0 2 20	32 Registrar's Sign	ature 4	W.)	9		

1150

Coe, Herman Arthur # 034860 - 4/24/05

			For Stata Registrer	State of Maryland / D		rtment of fificate o		d Ment	al Hygier	21115	15125
	Dhysisi	0.0	1. Decedent's Name (First, Middle, Last)			<u>.</u>		ite of Death		3. Time of Death
	Physicia /Medic		Anna D. Castelar					Apř		² 2005 (Pear	9:20 А м
	Examin	er	4a. Facility Name (If not institution, give				n, or Location of De			4c. County of Death	
	Funeral		Calvert Memorial I 5. Social Security Number 6. Se	x 7. Age (In yrs. last birt	thday)	If Under 1 Ye		Hrs. 8 Da	te of Birth	Calvert Co	place (State or Foreign ntry)
	Director		220-28-5177]M 2∭ F 72	Yrs.	Months Day	ys Hours M		onth, Day, Yea ch 8, 1		ryland
3	A ==		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Loca	ation					10d. Inside City Limits
	a-f sh	ctor	MD Calvert (County Lusby							1 ☐ Yes 2 📉 No
1	or 28	Funeral Director	10e. Street and Number			10f. Zip Code	9		10g. (Citizen of What Cou	ntry?
	8 238	rai	1830 Striped Bass		10.141	2065				J.S.A.	1- C-
	Item	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. W	Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	uerto Rican,	es or No- , etc.)	14. Race - Ameri Black, White	
2	iges I and 2 should be filed within 7.2 flours after beath with the Maryland of Healin and Mental Hygiene. It if in m 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Martical Examinar rotat be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1[☐ Yes 21XN	No Specify:			Specify: Whi	te
<u>ה</u>	"natu	Completed	15. Decedent's Edu (Specify only highest grad		(Give k	ent's Usual Occ ind of work do O NOT use ret	ne during most of	working	16b.	Kind of Business/Ir	ndustry
7	than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Cash		1164)		P.c	etail Stor	20
ב	other vent,	a l	17. Father's Name (First, Middle, Last)		Casi	TTCT	18. Mother's I	Name (First	, Middle, Maid		<u> </u>
<u> </u>	snould be ind Mental s marked o umatic eve	To B	James Irving Smith	1			Marga	ret T	ayman		
_ (h and h and 7 ts m traum		19a. Informant's Name/Relationship (T) Alberta Lee Stephe		•					y or Town, State, Zij \mathbf{oy} , \mathbf{Maryl}_2	
, ע	Health Health Iem 27 other tr		20a. Method of Disposition	20b. Place of	Disposi	ition (Name of				Location - City or T	
	rages nent of int; if it		1 Surial 2 Cremation 3 □I 4 □Donation 5 □Other (Specify)	removal from State	-	atory or other p		ril ^{Date} 2 2005		ıkirk, Maı	wland
Dallillor	permit. Prages 1 at Department of Hea Important; if item any injury or othe ance.		21. Signature of Fund at Service License	pe Dodone						Iome Calve	
٥	88288		My chart W. In							Owings,	MD 20736
	hysician /Medical Examiner	r	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ne cause on each line.	Caye (CAKAE		v, ~ ov	7	Approximate Interval Between Onset and Death
,00,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
ס מסי	death certiff e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnal Other (specify)				23d. Date of deliv Month	ery Day Year
Ĺ	gned b	by Pr	Part II. Other significant conditions co	ntributing to death but not resulting in	the unc	derlying cause	given in Part I.	2	3e. Did tobacc	o use contribute to t	he cause of death?
cords,	w requires inates by several sections of the second sections of the section of the sections of	ted t						- [1 🗆 Yes	22 No 3 □ Prol	bably 4 DUnknown
	ate ha	Completed						_	4a. Was an autopsy performed? □ Yes 251	death?	opsy findings available impletion of cause of
VIII	certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of I	Death (Che	ck only one)		
0	this c	To.	1 Yes 25 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T	tpatient Time of	OL OUN			Residence	6 Other (Special	(y)
5	th. ; After ; funer	tion	1=2Natural 5 ☐ Pending 2 ☐ Accident investigation		njury	28c. In V M 1	Vork?	200.0	oscribe now in	lary occurred	
DIVISION	to the nospital or Attending Fripsicients, within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, stree	et, factory, office	DB		ocation (Street ity or Town, Sta	and Number or Run ate)	al Route Number,
	ne Rospi n 24 hour he Funer pletely fills	edicai	29a. Certifier (Check only one) Certifying Phyone 2 Medical Example 1	raician: To the best of my knowledge iner: On the basis of examination and and manner stated.	dor inve	occurred at the estigation, in m	e time, date and play opinion, death o	ace, and du ccurred at t	ie to the cause he time, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
1	To the	Σ	29b. Signature and title of certifier	0 10			ense number		29d. [Date signed (Month,	
			1 Wand	V lado W			7610		N	p-1/ 19	2005
I	5		30. Name and address of person who can be be a supplied to the				e 310. P	rince	Freder	rick. MD 2	20678
	Sta		31. Date filed (Month, Day Year)	32. Registra Signature	10	1			2		

		1 - For State Registrar	State of Maryla	•	artment of H			ene	_ The
Dhysia	ion	Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	Oay Yea	3. Time of Death
Physic /Medi Exami	ical	Clarence 4a. Facility Name (If not institution, giv	James e street and number)	Carı		or Location of Deat	April 1	9 2005 4c. County of D	12:04 a M
Funeral Director		Chesapeake Hospic 5. Social Security Number 6. S	ex 7. Age (In yr.	s. last birthday) Yrs.	Lint If Under 1 Year Months Days	hicum If Under 24 Hrs. Hours Min.	(Month, Day, Y	ear)	Birthplace (State or Foreign Country)
pu ,		214–38–5498 Usual Residence of Decedent 10a. State 10b. County	100.0	Eity, Town or L	ocation		July 21	, 1940	Nash., D.C.
death with the Maryland ms 23a or 28a-f show r must be notified at	Director	MD Anne Aru	ndel		Lothi	an		-	1 ☐ Yes 2 🛣 No
with the a or 2		10e. Street and Number	3 ()		10f. Zip Code		10g	. Citizen of What	Country?
d within 72 hours after death with the Maryla giene, "naturel", or Items 23a or 28a-f show tr than "naturel", or Items 23a or 28a-f show the Madical Evantinel must be rediffed at	Funeral	128 Patuxent Mobi 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?		20711 Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecity Yes or No- o Rican, etc.)	USA 14. Race - A Black, W	merican Indian, hite, etc.
hours after nturel, or Ite	þ	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's E	1 ☑ Yes 2 □ No If Yes, Give Year or Dates unkn	own	1 ☐ Yes 2 🔀 No dent's Usual Occur	Specify:	16	Specify: Sb. Kind of Busine	white
within 72 ene. than "na	Completed	(Specify only highest gre Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retire COULDME	during most of word)	rking	construc	•
be file stal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last,		ilcav.	equipme	18. Mother's Nar	ne (First, Middle, Ma		21011
2 should be and Menta Is marked eumatic ev	2	Clarence Eugene 19a. Informant's Name/Relationship (19b. Maili	ng Address (Street		Elizabeth ura! Route Number, C	Chanes	
1 and Health em 27		Elizabeth Cattert 20a. Method of Disposition		Place of Dispo	Patuxent position (Name of matory or other pla		states, Lo	othian, I	
Page nent o ent: If ury or		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y) S	o. Memo	rial Gar	dens 04-2	22-2005 D	unkirk,	MD
permit. Departr Imports any inj		21. Signature of Funeral Service Lice	R Kros		2. Name and Addre	ĺ	ne, P.A.,	Owings,	MD 20736
		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the de one cause on each line.						Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	a. <u>metastati</u> Due to (or as a cons		r				
, p	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. liver met						
cate be executed physician and the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conso						
at the death certificate by the attending phy tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnanc	у		23d. Date of o	delivery Day Year
w requires that been signed by should be deta	by	Part II. Other significant conditions of	contributing to death but not re	esufting in the u	nderlying cause giv	ven in Part I.		cco use contribute	to the cause of death? Probably 4XIUnknown
The la ate has page 2	Completed						24a. Was an autopsy performe	prior t death	autopsy findings available o completion of cause of ? es 2 \sum No
Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital		104		th (Check only one)		Hospice
Phy this	on: To	1 ☐ Yes 2X No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time of Injury	f 28c. Injui	y at rk?	ome 5 Residence 28d. Describe how		pecify)House
or Atten frer deat irector: n by the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 200 Plane of Injury At	home, farm, st		Yes 2 □No	28f. Location (Stree City or Town, S		Rural Route Number,
To the Hospitel of within 24 hours a To the Funerel Completely filled in	edical C	29a. Certifier 1 X Certifying Ph (Chack only 2 Medical Example)	lysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier	7/		29c. Licens			. Date signed (Mo	
	1	30. Name and address of person who	completed cause of death (It		D 533	306	Ap	ril 19,	2005
8+1		Curtis Harris, M		gate Ro		11, Anna	polis, MD	21401	
St Regist	tate trar	31. Date filed (Month, Day, Year) APR 2	0 2005 Mars Sig	ara K	South)	9			

		_	For State Registrar	State of Marylan	d / Depa		lealth and N	Mental Hyg	•	05 15127
			1. Decedent's Name (First, Middle, Last)	$\overline{\mathcal{O}}$				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		LEAH -	AVIS				04		05 9:38 P M
	Examin		4a. Facility Name (If not institution, give s	treet and number)			r Location of Death	•	4c. County	of Death
			716 Lowander Lane 5. Social Security Number 6. Sex	7. Age (In yrs. i	last hirthday)	Silver If Under 1 Year		9 Date of Right	Montg	
	Funeral Director			M 2\(\tilde{X}\) F 75	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthplace (State or Foreign Country) Tennessee
	D		Usual Residence of Decedent					, ipili J.	, 1,2,	
	anylar show	_	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	Maryland Montgomer	y S	ilver	Spring 10f. Zip Code			10g. Citizen of W	A
	with Ba or		716 Lowander Lane			2090	11			States
	death	Funeral		2. Was Decedent Ever in U.	S. 13.		dispanic Origin? (Span, Mexican, Puerl	pecify Yes or No-		- American Indian,
9	after or Ite	/Fu	1 ☐ Never Married 2 📉 Married	Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give	-	1 ⊡Yes 21X No	Specify:	o nican, etc.)	Specify:	k, White, etc.
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						White
1 5-	c * #	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor.	king	16b. Kind of Bu	siness/industry
212	a filed within I Hygiene. other than "	ome	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemake	er		Own	Home
g	be filed stal Hygid ad other event, L	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,		
<u>yla</u> ı	2 should be and Mental is markad o aumatic eve	To	Michael Roser	berg			Gussie	Mi	1grom	
Maryland	les 1 and 2 should b of Health and Ment of Hem 27 is marked or other traumatic		19a. Informant's Name/Relationship (Type				and Number or Ru			
	1 and Health em 27 ther t		Morton A. Davis, 20a Method of Disposition	husband 20b. P			Lane, Si	Lver Spr		20901 City or Town, State
Baltimore,	Pages ant: If ite		1 X Burial 2 ☐ Cremation 3 X Re 4 ☐ Donation 5 ☐ Other (Specify)	amovai irom State		osition (Name of matory or other place Cemetery		/2005		
Ħ	permit. Pages Department of Important: If it any injury or g		21. Signature of Funeral Service License		_				Washing	
ä	Dep Imp any		Donald ()	/ Lee	er 1	anzansky- 170 Rockv	ss of Facility Goldberg Ville Pik	Memoria e, Rockv	ille, M	ls, Inc. 20852
		23a. Part1. Enter the disease, or complications that caused the path. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
	Pnysician		Immediate Cause (Final disease or condition	Small Cell I	Lung C	ancer				Onset and Death 18 Months
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
171	uted d ansit	Examiner	Causa (Discasa of Hijury							
ó	ite be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
3760,	9 × 6	cal	d	•						
x 68	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna						
Вох	attenc for us	lan/	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	Ideath 3	Ectopic pregnancy Other (specify)	4		23d. Date Mon	of delivery oth Day Year
o.	at the de by the a	yslo	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9 Unknown	eaus Sc					
Δ.	the bed	by Pt	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
Records,	ed plan							1 X] Y	es 2□No	3 ☐ Probably 4 ☐Unknown
900	e law requ has been je 2 shouli	plet						24a. Was a	an 24b. W	Vere autopsy findings available rior to completion of cause of
<u>~</u>		Completed						perform 1 ☐ Yes	med? d	eath? □ Yes 2□ No
Vital	Physiclan: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	ospital:		0,4		th (Check only or		
of	Phys this al dii	10 10	1 ☐ Yes 2X No	1 Inpatient 2 28a. Date of Injury	ER/Outpaties 28b. Time o	nt 3□ DOA	1er: 4 ☐ Nursing H	ome 5X Residence 128d. Describe he		
	ng After Ine	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	rk? Yes 2 □ No	200. 2000.100 (1.	ow injury cooding	
Division	I or Attending after death. Director: After I in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho		reet, factory, office				er or Rural Route Number,
Ö	F the F	Certification	4 Homicide	building, etc. (Specify	y)			City or Tow	n, State)	
	To the Hospital of within 24 hours after the Funeral D completely filled in	Medical	29a. Certifier 1∑ Certifying Phys (Check only one) 2 ☐ Medicel Exemin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and mar late and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	2 44 3		29c. Licens	se number	2	9d. Date signed	(Month, Day, Year)
)			► 1777×1-+1	e, MD		ME80	729		April 1	.5, 2005
	12		30. Name and address of person who co		, , , , ,					
			Martin Gutierrez,				ve, Rocky	ville, M	20852	2
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 0 200	32 Registrar's Signa	t sp	uli				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					aryland / i	Certificate		Death	nemai my	Reg. No. 2	105	15100
	Physicia	n	Decedent's Name (First, Middle	•					2. Date of D Month		Year	3. Time of Death
-	/Medica		Marie	Antoinette		Davis				16, 200	5	5:09 pm
1	Examine	er	4a Facility Name (If not institution					4b. City, Town, or L	ocation of Dea	th 4c. Count	y of Death	
_			Heritage Harbon 5. Social Security Number	_		rthday) If Under		Annapolis If Under 24 Hrs.	1		Arun	
	Funeral Director		216-44-5115	1 M 2 F 7. A	ge (In yrs. last bii 92	Yrs. Months		Hours Min.	8. Date of Bi (Month, D	rth ay, Year)		lace (State or Foreign
			Usual Residence of Decedent						8/15/	1912	Mary	land
	how I		10a. State 10b. County		10c. City, Tow	n or Location					10	Od. Inside City Limits
	Maria Maria	5	MD Anne A	Arundel	Annapo	lis						1□Yes 2□No
	章 9 章		10e. Street and Number	***		10f. Zip	Code			10g. Citizen of	What Count	try?
	23.	Funeral Director	1905 Hunt Meadow	v Drive		21	403			United	States	5
	ar de	E L	11. Marital Status	12. Was Decedent Armed Forces)	13. Was Decede	ent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14. Ra	ce - America	
21215-0020	urs a	ক্র	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	lf Yes 2 ☑ If Yes, Give Year or Dates:	No	1□Yes 2					∜: Whit	
5-(72 h	Completed	15. Decedent' (Specify only highes	s Education	16a.	Decedent's Usual	l Occup	pation during most of work	rina	16b. Kind of E	Business/Ind	lustry
121	within iene. then	ğ E	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of work d)	,,,g			
2	be filed withintal Hygiene. d other than		12 17. Father's Name (First, Middle, L	1		Homemak	er				Home	
au	should be filed withing Marked other than marked other than maric event, the Marked other than matic event, the Marked other than matic event, the Marked other than Marked ot	Be	Vincent Joseph	*				18. Mother's Nam Christi			me)	
<u> </u>	should be and Mental in marked of immatic even	2	19a. Informant's Name/Relationsh		106	Adolling Address	/C+				0	
Maryland	thar trau		Margery A. Davis					and Number or Run Meadow D:				
Je,	s i and s f Haalth Item 27 I	-	20a. Method of Disposition		20b. Place of	Disposition (Nam	e of		Date	20c. Location	•	
Baltimore,	00-	İ	1 ☐ Burial ★ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from State		ry, crematory or oti itan Crema	,	H	pril 19,	Alexand		
=	parmit. Peg Dapartment Important: f any injury o	ŀ	21. Signature of Fureral Service L		recepti				005 ant Filman			Services,Inc.
ä	Par) Drack	Su.	M00982	42 Hudso	n St	. Suite 110	Annapo	lis, Mary	land 21	401
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	nly one cause on each li	the death. Do no.	not enter the mode	of dyir	ng, such as cardiac	or respiratory a	ırrest,	1	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final			1		1. 1	/		1	Onset and Death
d.	Examiner		disease or condition resulting in death)	a		Lowe	1	GIB	leed	_	:	
		-			Due to (or as a	consequence of):	7	100			1	i
	uted d ensit	Examiner	0	b	D		e (rac (en	nce	<u> </u>	ĺ	
ó	requires that the death certificate be assecuted been signed by the attending physician and chould be datached for use as the burial-trensit	LX.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	consequence or):					1	
68760,	iysick	20	that initiated events	C	Due to (or as a c	onsequence of):						
89	ng ph	5	resulting in death) Last		(Ī
Вох	th ce tandii or use	3		d							-	
<u>.</u>	e dea ha at ned fo	rnysician/medical	Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying car	use giv	en in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
P.O.	d by			lovere	Ane	muei			10	Yes 2□ No	3 ☐ Prob	ably 4⊟Unknown
S,	ras the signed of be of	2		0							1	
of Vital Records,	The lew requires that the death cerate base been signed by the attendir page 2 should be deteched for use	20		July	e ho	howe	3		24a. Was	an autopsy med?	avai	e autopsy findings lable prior to
ခို	2 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	2		1 - 0 - 11	1 0						of de	pletion of cause eath?
- .	ysician: The is certificate he director, page			Deage	Coll				10	Yes 2 No	1 🗆	Yes 2□ No
⋚	Physician: The rhis certificate rel director, pages recognitions.		25. Was cese referred to medical examiner?	Hospital:			Oth	26. Place of Death	(Check only	оле)		
	Physical rithis can direct dir		1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie		tpatient 3 DOA	c. Injun	4 Nursing Ho		dence 6 Oth		
o	After fune	2	1 Natural 5 Pending 2 Accident investiga	(Month, Da		njury M	Worl		zod. Describe	now injury occur	190	
Division	Attending or deeth. actor: After by the fune	2	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Inj	Jry - At home, fai	rm, street, factory,			28f. Location (Street and Numl	per or Rural	Route Number
ă	tal or Attending P rs efter deeth. al Director: After t led in by the funer		4 Homicide	building, etc	c. (Specify)				City or To	vn, State)		
	To the Hospital or Attending Phywithin 24 hours either deeth. To the Funeral Director, After thi completaly filled in by the funeral Madical Ceretts continued.	al cal	29a. Certifier 17 Certifying (Check only one)	Physician: To the best caminer: On the basis of and manner sta	examination and	death occurred at	t the tim	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and madate and place,	anner as sta and due to t	ted. the cause(s)
	Vithin Forth	_	29b. Signature and title of certifier	5		29c.	License	number .		29d. Date signe	d (Month, D	ay, Year)
			> 7	Hund	X	1)5	7897		4/141	05	
			30. Name and address of person w	no completed cause of d	eath (Item 23a) (Type, Print)	0	111N/2	0000	0	000	0 3 3 5
			31. Date filed (Month, Day, Year)	32 Banish	ar's Signature	EATSI :	100	76	10000	COMIS	516)	5 Cottonorus
	State Registrar	4	a DD 1	0 2005	a olynature	A. N	,			dia	428	
2411	IN 16 Day 6/06		APK T	y. ZUUD	MARI SA	STATE .	_					

			State	of Maryland	d / Departm			Mental Hy	giene		
					Certific	ate of	Death		Reg. No.		
	Dhysici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year 3.T	ime of Death
	Physici /Medic		Alvin Harry	Doc	ve			Apri		2005 11	:15 AM
-	Examir		4a Fecility Name (If not institution, give street and no	u <i>mber)</i>		- (4b. City, Town, or				1
			2804 GRIER	Nizes	SERY 1	Road	Fores	t Hill	Ho	er for	d
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la		nder 1 Year ths Days	If Under 24 Hrs	8. Date of Bir (Month, Da		9. Birthplace (S Country)	
100	Director		216-16-3130 ¹ \ [™] ^{2□} F	83	Yrs.	uns Days	Hours Min.	4/5/19	22	Maryla	
	D		Usual Residence of Decedent					1 7 -/ -/			
	ylen how	.	10a. State 10b. County	10c. City,	Town or Location					10d. Ins	side City Limits
:	Ma F	호	MD Harford		Forest	H i11				10]Yes 2√∏No
	128 128	ie	10e. Street end Number		10f.	. Zip Code			10g. Citizen of V	Vhat Country?	
	3a o	2	2804 Grier Nursery	Road		2105	0		,	USA	
	within 72 hours eiter deeth with the Marylend ene. Then "natural", or items 23a or 28a-f show the Modical Ext. viner mast be notified at	Funeral Director	11. Marital Status 12. Was De	cedent Ever in U.S	5. 13. Was Do		lispanic Origin? (S an, Mexican, Puer	pecify Yes or No		e - American Ind	ian,
<u> </u>		2	Armed F 1 □ Never Married 2 □ Married 1 ★ Yes	2 □ No			an, Mexican, Puer	to Rican, etc.)	Blac	k, White, etc.	
8	urs e	þ	3 Widowed 4 □ Divorced If Yes, G Year or	aive Dates: WWII		s 2/2 No	Specify:		Specify	White	
Ŏ,	2 hou	Completed	15. Decedent's Education		16e. Decedent's U	Jsual Occup	ation		16b. Kind of Bu	siness/Industry	
7.2		pie	(Specify only highest grede completed		(Give kind or life. DO NO	f work done i Tuse retired	during most of wo	rking		1	
7	tha en	E	Elementary/Secondary (0-12) College	(1-4or 5+)	Inspect	zor			Manufa	acturi	ng
ם :	be filed tal Hygi d other event, I		17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,			
<u>a</u>	d be ental ced c	To Be	Harry Eldred Dowe				Hu1a	McCann			
Maryland 21215-0020	should be filed very marked other to marked to marke	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Add	ress (Street	and Number or Ru		er City or Town	State Zin Code	
<u>S</u>	alth er 27 is 37 is		Susan C. Vaughan/daught	or	_	,					
ď,	l and Health em 27 vther tr	-	20a. Method of Disposition	20b. Pla	ace of Disposition	Name of	Jrsery Ro	Date Date		City or Town, St	21050
و	Pages nent of l int: if ite		1 XBurial 2 ☐ Cremation 3 ☐ Removal from	State Pol	metery, crematory Air Memori	or other place		5/2/2005			410
	permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryler Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in Hipportant; if item 21 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	-	4 □ Donetion 5 □ Other (Specify)	1331				1/2/2005	Bel Air	, MID	
39	permit. Departm Importai eny inju		21. Signature of Funeral Service Licensee	4	1		ss of Facility				
	4D = 0 0		1 /4 July & nowth	1/1	Harki	ns rune	eral Home,	mc.,600 M	ain St.,D	elta, PA	17314
			23a Part1 Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death.	Do not enter the	mode of dyin	g, such as cardia	or respiratory a	rest,	Appro	ximate al Between
, F	hysician		,								and Death
1000	/Medical		Immediate Cause (Final disease or condition	EREB	145	LASA	CALCE	Anc	DEXT	1	
E	Examiner		resulting in death) a.		as a consequence		OKAK	1 100	TEN	1	
		ner									
V	Ine law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-trensit	edicai Examiner	Sequentially list conditions	Due to (or	as a consequence	of):					
oʻ l	exe an an	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	•		•					
68760,	ysicii ee	Cai	that initiated events	Due to (or a	as a consequence	of):					
89	mica goph astt		resulting in death) Last								
Вох	andin use	2	d								
m	atte d for	Cia	Part II. Other significent conditions contributing to c	death but not recul	ting in the underlyin	on cauco aiv	on in Port I	22h Did	obacco use cor	stribute to the ex	use of death?
Q	Sche The	hys	Value Calculation Conditions Continuently to	douth but not resul	ung in the dilderly	ig cause giv	on in raici.				
<u>п</u>	ned k	Completed by Physician/M						10	Yes 2 No	3 ☐ Probably	4 Unknown
Vital Records,	ulres uld blu	0						24a. Was	an autopsy	24b. Were aut	
<u>ဂ</u>	beel shou	ete						perfo	rmed?		prior to in of cause
Ë Ë	has ge 2	립								of death?	
	certificate rector, pag	ပိ						101	08 2 200	1 🗆 Yes	2□ No
\ \frac{1}{2}	Auending Prhysicien: ar death. ector: After this certific by the funeral director,	Be	25. Was case referred to medical examiner? Hospital:		-	Oth		ath (Check only o	164		
to a	this (raidir	۲	TLI Tes 212/NO	1		DOA Oth	4LI Nuising F	lome 5 Resid			
2	oner uner	Ö	i pag tatulai o E i citaling	or injury nth, Day Year)	28b. Time of Injury	28c. Injun Worl	k?	28d. Describe i	now injury occurr	ed	
Sic	eath or: A	cat	2 Accident investigation 3 Suicide 6 Could not be		М		Yes 2 □ No				
	fter of free of n by	E	determined 286. Plac	e of Injury - At hon ding, etc. (Specify)		tory, office		28f. Location (S City or Tox	Street and Numbern, State)	er or Rurel Route	Number,
	Is a line i led i	ပီ									
	to the nogetal or arenamy prystoren: the within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Certification: To	29a. Certifier (Check only (Check only 2 Medical Examiner: On the t	basis of examination	ledge, death occurr on and/or investigat	red at the tim	ne, date and place	, and due to the	cause(s) and ma	nner as stated.	use(s)
-	the Ithe Ithe Ithe Ithe Ithe Ithe Ithe I	2	one) and mai	nner stated.							
	Son Son	2	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	(Month, Day, Yo	ear)
			· Conx H,	·v		100	0550	35	412	1/05	
	2		30. Name end address of person who completed cau	use of death (Item 2	23e) (Type, Print)	,		1	1	1	
_	4		Lynn Hallarman	J. W.C	3906	book	ch Rav	en Bh	& Balt	imar T	BICICUM
	Sta	te	31. Date filed (Month, Day, Year) 32.	Registrar's Signatu	ire					7	
	Registr	ar	MAY U 4 2005 Man	Da . Ph	Constell						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 April 16, **Physician** Wilna L. Drehmel 9:05 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince Freuerro.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 27, 1914 Wisconsin Calvert Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1□M 2√2F Yrs. 213-38-2797 90 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Items 23s or 28s-f show treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Calvert Solomons Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle 20688 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 🛣 No Specify: Specify: White Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) School Secretary Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Albrecht Leona Ewald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis C. Drehmel (Son) 3208 Killdalton Place, Apex, N.C. 27539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 04/22/2005 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician archar 5 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardio vascular distase tiner oscienchic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Multiple 1 Yes 2 4No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 50653 1-16-2005 -an GYAN . C. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURANIA 851. churchton Deale Road 31. Date filed (Month, Day, Year) 32. Registras Signature State 2 0 2005 Blocker Registrar

1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 12:30 A^M 19 2005 April FRANCIS ENGLISH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Sligo Creek Nursing and Rehab. Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Yrs Cambridge, MA Director 032-01-2503 88 3, 1917 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at by Funeral Director 1X Yes 2 No Prince George's Hyattsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 1608 Amherst Road 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced "natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction/Electrical Construction .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if Item 27 is marked other t jury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ David English Mary Daly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace 1608 Amherst Road, Hyattsville, Maryland 20783 Gorace English, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buria 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 4/21/2005 Silver Spring, MD Gate of Heaven 21. Signature of uneral 2 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dise e or condition resulting in death) Physician Pulmonary Adema /Medical Due to (or as a consequence of) Examiner Convestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons » uence of Examiner rsician and s burial-transit The law requires that the death certificate be executed Infected decubitus ulcer resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician s the burial Physician/Medical Diabetes Mellitus, Possible Sepsis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2X No 1 Yes 2 🗌 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ٥ 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 Residence 6 Other (Specify) Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lin by 4 Homicide To the Funeral Dir 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number De 4/19/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 1 2005

Achankunju Chacko, M.D., 7610 Carroll Ave, Suite 390, Takoma Park, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 19:51 M Mary K. English 19 2001 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death AGNES HEALTHCARE IMORE None | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 28, 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland 1 □ M 2 🗗 F Yrs. 220 18 5813 78 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 1 Tyes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Baldwin Court Apt H 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Merhle F. Butler Mary Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald R. Rider/Son 1510 Ridge Road Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Crest Lawn Mem. Gard. 4-25-2005 Marriottsville, MD 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee when M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIVERTICULUSIS disease or condition resulting in death) 720 YEARS CHRONIC OBSTRUCTIVE PULMONARY DISTASEDUE to (or as a consequence ot): YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury METABOLIC that initiated events resulting in death) Last Due to (or as a consequence ot) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2**X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director MD

Completed by Funeral

traumatic event, the Mudical Examiner must be notified at

permit. Pages 1 and 2 should be tiled within 72 hours after death with it Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23e or 21 any njury or other traumatic event, it is Musical Exercises 23e or 21 any njury or other traumatic event, it is Musical Exercises.

the Maryland

Hospital or Attending Physician: After death. 24 hours after deat filled in by

P.O. Box 68760,

Certification

EX	resui
clan/Medical	IF FE 23b.
ed by Phys	Part
Be Completed by	25. V
To	25. V 9

EMALE Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

Vas case referred to medical examiner? ☐ Yes 2 No 1 Xinpatient 2 ER/Outpatient Manner of Death

5 Pending investigation 6 Could not be 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of

3□ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

AVENUE, BALTIMORE, MD 21224

28t. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier?

1 Natural 2 Accident

3 Suicide

(Check only one)

29a. Certifier

SA 24385283532

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) APRIL 19, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 WU $\mathcal{M}\cdot\mathcal{U}$

strar's Signature

Registrar

completely

within 2 To the To the

Medical

			1 - For State Registrar	State of Mary		artment of I rtificate of		nd Me		jiene 0 0	5	151	33
			1. Decedent's Name (First, Middle, La	st)				2	. Date of Dea	th		3. Time of	Death
	Physici /Medio		Frances A.	Eybers				A	Month pril		rear 105	5:30	\mathbf{P}^M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of	Death		4c. County o		1	
			3812 Gawayne Ter	race			r Sprin			Montg	ome	ry	
	Funeral		5. Social Security Number 6. S	CM ONE	yrs. last birthday)	If Under 1 Year Months Days		4 Hrs. 8	. Date of Birth (Month, Day	, Year)	9. Birthp	lace (State or	r Foreign
	Director		223-24-7173		0 Yrs.				ov. 17	, 1924		gínia	
	and *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation					1	0d. Inside Cit	ry Limits
	/anyl	ō	Maryland Montgor		Silver							1 Tyes	-
	28a-	ect	10e. Street and Number		DIIVCI	10f. Zip Code				log. Citizen of Wh	at Cour		
	with Sa or	٥	3812 Gawayne Te	rrace		2090	6			United		,	
	within 72 hours after deeth with the Maryland ane. then "naturel", or ltems 23a or 28a-f show he Maulgell Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of I		in? (Specif	v Yes or No-	14. Race			
(0	riter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cub	an, Mexican, I	Puèrto Ric	can, etc.)		White,		
93	ol', o	by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify:	Wh	ite	
20	72 ho	Completed	15. Decedent's Education (Specify only highest gra	fucation	16a. Dece	dent's Usual Occu kind of work done	pation	of working		16b. Kind of Bus	ness/Inc	dustry	
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	or working					
2	filed w Hygier other th	Co	12		Secre	etary				Washing		Post	
nd		a)	17. Father's Name (First, Middle, Last,					,		Maiden Surname,)		
<u>×</u>	Men Men Marke	은	Clifton Hough						Lawso				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 le marked can yinjury or other treumetic evonce.		19a. Informant's Name/Relationship (ng Address (Street						,	
6	tealth her t		Norman Taylor / 20a. Method of Disposition		1942 Ob. Place of Dispo	1 Poinse	tta Co	urt					
10	o = in		1 X Burial 2 Cremation 3		cemetery, cre	matory or other pla	ice) A	pril	21.	20c. Location - C			
Ë	tant:		' 4 □ Dogation 5 □ Other (Specif			1 Cemete	ry 20	005	S	uitland,		ryland	
33	Depar Mpor Iny Ir		21. Signature of Funeral Service Licer	TS88		2. Name and Addre		2011		eral Hom			
	405 e d					DE. Deer					MD		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	death. Do not en	ter the mode of dyl	ng, such as ca	ardiac or r	espiratory arr	est,		Approximate Interval Betwonset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Myocardia	1 Infarc	tion						011001 2110 0	02.11
	/Medical Examiner		Toolsting in docum	Due to (or as a cor	nsequence of):								
		-	Sequentially list conditions,	b. Due to (or as a cor	requence of):								
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (0, 45 2 00)	isoquomoo ory.								
	xecu and al-tra	хаг	that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and sage 2 should be detached for use as the burial-transit	alE		-									
687	ficate phys s the	edical		d									
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro-	egnancy					23d. Date	of delive	rv.	
ğ	atte	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		☐Ectopic pregnanc ☐ Other (specify)	у			Monti			ear
0	by the a	Jysi	9 ☐ Unknown	9 Unknown									
<u>م</u>	s that	by PI	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	inderlying cause gir	ven in Part I.		23e. Did tot	bacco use contrib	ute to th	e cause of de	ath?
rds	quires in sign	a pe							1 🗆 Ye	s 2□No 3	Proba	ably 4X U	nknown
8	aw require	lete							24a. Was a	n 24b. We	re autor	osy findings a	vailable
Re	The la	Completed							autops	ned? pri	or to con ath?	npletion of ca	use of
Vital Records,		0	25. Was case referred to medical				26 Place of	of Death (C	1 ☐ Yes 2 Check only on] Yes	2 L No	
>	Physician: this certific al director,	0	examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Ot	ner.			ence 6 Other	(Specify		
of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Inju	ry at			ow injury occurred		/	
jor	Attending Ir death. ector: After by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		ur) Injury	M 1 [rk?]Yes 2∐No	0					
Division	ar de:	iffic	3 Suicide 6 Could not b	28e. Place of Injury - building, etc. (Sp	At home, farm, str	reet, factory, office		28f	Location (St City or Town	reet and Number	or Rural	Route Numb	10 <i>r</i> ,
Ö	s afte el Din	Certification:	Tomodo	ounding, etc. (3)	ochy)				Oily of Town	i, State)			
	Hospitel A hours a Funerel i		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, deat	h occurred at the ti	me, date and p	place, and	due to the ca	ause(s) and mann	er as sta	ated.	
	he H in 24 he Fi	edical	one)	niner: On the basis of examend manner stated.	mination and/or in	vestigation, in my o	opinion, death	occurred	at the time, da	ate and place, an	d due to	the cause(s)	
L.	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Σ	29b. Signature and title of certified			29c. Licens	se number		2	9d. Date signed (Month, E	Day, Year)	
•	12		are M	Ma mr		03	345	5	P	DR:11	8	200	5.
			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)		1					
			Edward P. Taubm			e Philip	Dr. 7	#275	01ney	, MD 208	332		
	Sta		31. Date filed (Month, Day, Year)	005 32 degistrar's S		artes							
	Registr	aı		THE WAY	2	-3747.00							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 17^{Day} 2005 Year **Physician** Month APR ANNIE MILDRED FRAZIER 3:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Jan. 25, 6 Sax Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Year 1 □ M 2 T F Yrs Director 237-42-6103 73 1932 North Carolina Usual Residence of Decedent death with the Maryland 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits ral', or Iteme 23a or 28a-f ehow Examiner must be notified at 1X Yes 2 □ No Completed by Funeral Director MD Prince George Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7314 Webster Turn 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 BYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) | Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Staff Sargent USAF 12 other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Faut: If Itam 27 Is marked of Jackson Brooks ٩ Annie Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Itam 27 I Clarence Frazier/Husband 7314 Webster Turn, Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Vet. Cem. 4/22/05 ' 4 Dopation 5 Dother (Specify) Cheltenham, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd, Camp Springs, MD 20748 Fig. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE MYELOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ig physician and as the burial-transit The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 TYAS Hospitel or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 24 hours a 29a. Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 21316 (AL) se of death (Item 23a) (Type, Print) 30. Name and address of person who completed NATIONAL NAVAL MEDICAL

DHMH 17 Rev 1/2001

State

Registrar

Box 68760.

P.O. I

Division of Vital Records.

BETHESDA MD 20889-5600

LCDR

REID D. HOLTZCLAW

APR 2 0 2005

31. Date filed (Month, Day, Year

MC

2. Registrar's Signature

		,	1 - For State Registrar	State of Maryla	_	artment of I			Hygier	2005	15135
	Physici /Medic		1. Decedent's Name (First, Middle, Las Frank Foster	()				Monti		Day Year 2005	3. Time of Death
ذ	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of			4c. County of Deat	
			Washington Advent			Takoma				Montgome	
	Funeral Director		5. Social Security Number 250-46-6349 Usual Residence of Decedent	ex 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days		Min. (Mont	of Birth h, Day, Yea 27,	9. Birth Co 1932 Sout	nplace (State or Foreign untry) th Carolina
	fand ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Many Med	tor	MD Prince (Georges Ne	ew Carr	ollton					1x√TYes 2 No
	or 28	Olrec	10e. Street and Number			10f. Zip Code			10g.	Citizen of What Co	untry?
	ath w	Funeral Director	6625 Chestnut Ave			207				USA	
	er de Items	nue	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Decedent Ever in I Armed Forces? 1 ★Yes 2 No	J.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Specify Yes n, Puerto Rican, etc	or No- c.)	14. Race - Ame Black, White	
36	ol', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 20XNo	Specify:			Specify: B1:	ack
21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show iteal Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occu	pation	t of working	16b.	. Kind of Business/	
215	ithin 7 16. 16n "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)				
2	led w lygier her th		12th 17. Father's Name (First, Middle, Last)		Admi	nistrati		sistant er's Name <i>(First, M</i>		overnmen	t
anc	d be findal Fed of	o Be	George Forter						Jnk.	en sumame)	
Maryland	should nd Me mark matig	ĭ	19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Maili	ng Address (Stree			lumber, Cit	y or Town, State, 2	Zip Code)
Z	alth a		Georgia M. Fost	er/ Wife	6625	Chestnu	t Ave	. New Car	rollt	on, MD 20	0784
altimore,	es 1 a of Hea f Item r othe		20a. Method of Disposition		Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ace)	Date	20c.	Location - City or	Town, State
Ĕ	Pagement ent: It		1 ⊠ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Han						ndover, l	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-f show amount injury or other treumatic event. The Medical Examinar must be notified at once.		21. Signature of Funeral Service Licer	- Jenty						enkins Fo	uneral Home 20011
	Physician		23a. Part 1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition	plications that caused the decone cause on each line.	ath. Do not en	ter the mode of dy	ing, such as	cardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a conse	quence of):	eft gree	t to	-			2-3 weeks
	cuted nd rransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Jangrene Due to (or as a conse c. Penpheral Due to (or as a conse	quence of):	les de	sear	/			2-3 weeks 10 years 20 years
8760,	ficate be executed physician and is the burial-transit		resulting in death) Last	d. Dialettes	quence of):				· · · · · · · ·		20 yeur
.O. Box 68	the death certi y the attending ched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[□Ectopic pregnand □ Other (specify) _	су		_	23d. Date of deli Month	ivery Day Year
Vital Records, P.	se.	Completed by Ph	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	underlying cause g	ven in Part I	. 23e.	Did tobacc		the cause of death?
COL	≥ 11 °S	lete	Permane arter	ey diserre	_			24a.	Was an	24b. Were au	topsy findings available
Re	9 - 9	omp	G. 1 Stage Rene	ey disease	-			10	autopsy performed Yes 2 💯	? death?	completion of cause of
ital	iclen: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place	e of Death (Check		10 12 100	
of V	d is	To	1 ☐ Yes 2 🗹 No		☐ ER/Outpatie	III JE DOA		ursing Home 5	Residence	6 ☐Other (Spec	cify)
		lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	W	ork?		cribe how in	njury occurred	
Division	tent feati tor: the	ertification:	2 Accident investigation 3 Suicide 6 Could not b		home farm st		Yes 2		tion (Street	and Number or Ru	ıra i Boute Number
Σ	i gite	ertii	4 Homicide determined	building, etc. (Spec	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	City	or Town, St	ate)	,
	8 4 5 5	edical C		ysician: To the best of my kinner: On the basis of examinand manner stated.							
433	To the Ho within 24 To the Fu	Me	29b. Signature and title of certifier				ise number		29d.	Date signed (Month	h, Day, Year)
	2		. G. Chutruth	MD		32	119		9	18/05	
K	-(5)	1	30. Name and address of person who	completed cause of death (It			un a-	70/			
	0		31. Date filed (Month, Day, Year)	2. Registrar's Sig		ANHAM	10 20	Ub			
	St Regist	ate rar	APR 2 0 2005		ha	(e)					

			1 _ State	-	artment of Heal tificate of Dea			2005	12107
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	incate of Dea		Reg 2. Date of Death	. No. ← U U U	3. Time of Death
	Physicia /Medic		Evelyn Powell Fagin			A	Month April 17	Day Year	8:10 P ^M
}	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca			4c. County of Death	
		Ц,	Washington Adventist Hospi		Takoma Par			Montgomer	<u> </u>
	Funeral Director		579-05-4977 1□M 2CIF	(In yrs. last birthday) 88 Yrs.		Under 24 Hrs. ours Min.	B. Date of Birth (Month, Day,) Aug • 9,	$\stackrel{\text{(ear)}}{1916} \stackrel{\text{(9. Birth}}{Wash}$	place (State or Foreign intry) ington, DC
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl -1 sho	ţŏ	D.C. N/A	Washingto	on				1 X Yes 2 □ No
	th the	lrec	10e. Street and Number		10f. Zip Code		100	. Citizen of What Co	untry?
	ath wi	ralD	201 Quackenbos Street, N.W.		20011			United Sta	tes
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 to marked other then "netural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ No. If Yes, Give Year or Dates:) I	Mas Decedent of Hispan f Yes, specify Cuban, Me I □ Yes 2🌠 No Sp	nic Origin? (Spec lexican, Puerto R pecify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify:	
2-0	72 hou neture	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during	a most of working	16	6b. Kind of Business/I	
21215-0036	within jene.	Completed	Elementary/Secondary (0-12) 12 College (1-4or 5-1)	life. L	nistrative			Federal Go	vernment
d 2	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)		18. [Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland	outd b Menta	2	John Roy Powell		•	ueen Rod			
Mar	d 2 sh th and 7 le m treum		19a. Informant's Name/Relationship (Type, Print) Wendall B. Fagin (son)		eg Address (Street and A Emerson Sti			City or Town, State, Z ${\sf nington}$, ${\sf D}$	
<u>ē</u>	Heali tem 2		20a. Method of Disposition		sition (Name of natory or other place)	Da		c. Location - City or	
altimore,	Page nent o ant: If		1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)		ike Crematoi	ry 4/20	/05	Beltsville	, MD
Balt	ermit. epartr nporte ny inju		21. Signatur 1 Funeral Service Licensee		. Name and Address of I				
	<u>0</u> 05€0		23a. Part 1. Enter the disease, or complications that caused		400 Georgia				D.C. 20012 Approximate
	Physician :		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	ivaenic	Short	e K	respiratory arres	(,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	consequence of):	10 11	0 1	1 -		a lays
		er	Sequentially list conditions, if any, leading to immediate	consequence of):	ate Mybe	cardia	1 th	arction	2 Lays
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	, ,	9				
ó,	ficate be executed physician and is the burial-transit		and the state of t	consequence of):					
68760,	icate b physic s the b	edical	d						
-	Th (7)		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	of pregnancy				23d. Date of delin	verv
.O. Box	law requires that the death certi as been signed by the attending 2 should be detached for use a	Physiclan/M	in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
<u>α</u>	that the od by detac		Part II. Other significant conditions contributing to death bu	t not resulting in the ur	nderlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	w requires been sign should be	Completed by	Cerebrovascular Ac	cident			1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
Seco	e law r has be	nple	Gastrointestinal B1	eeding			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
a F	Th ate pag		Acute Kenal tailu	re			-/-	No 1□Yes	280 No
5	Physicien: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatien	t 2 ER/Outpatien	Other	-	(Check only one)	ce 6 Other (Spec	(Az)
u of			27. Manner of Death Natural 5 ☐ Pending 28a. Date of Injury (Month, Day	28b. Time of			3d. Describe how		.,,,
Sio	Attending r death. ector: After	catle	2 Accident investigation		M 1 Yes				
Division	of or Attendated after death Director:	Certification:	4 Homicide determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, str (Specify)	eet, factory, office	28	City or Town,	et and Number or Rui State)	al Houte Number,
-	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of	f my knowledge, death	occurred at the time, da	ate and place, ar	nd due to the cau	se(s) and manner as	stated.
	To the H within 24 To the F complete	Medical	one) and manner stat	ed.					
	T W T O	_	29b. Signature and title of certifier	W 111	29c. License num	521101	, 29	I. Date signed (Month	1005
•	4		30. ame and address of er if why impleted cause of de	ath (Item 23a) (Type,	Print)	70/		PVIII)	acco)
			Inomas IVI. Hornyis, W	D. 76000	arroll Avei	The 199	Lung to	VK, MD	20912
	Sta Registr		31. Date filed (Month, Day, Year) 32 degistra APR 2 0 2005	r's Signature	will	,		/	
			ARRESTON	- 1					

			1 - For Stete Registrar	State of M	aryland / [Depart		lealth a	and Mo			005	15137
	Physici	an	1. Decedent's Name (First, Middle, Las	•			-			2. Date of Deat Month	th Day	Year	3. Time of Death
	/Medic	al	Wade Klet Forman							Apri1	23,	2005	11:39a ^M
	Examin	er	4a. Facility Name (If not institution, give			4	b. City, Town, o		of Death			ounty of Death	
	Funeral		Garrett County M 5. Social Security Number 6. S		O SPÍTAL e (In yrs. last bir		0ak1an f Under 1 Year	If Under 2	24 Hrs.	8. Date of Birth (Month, Day)		rrett 9. Birthi	place (State or Foreign
п	Director		5/3-38-9659	⊠ M 2□F	87	Yrs.	lonths Days	Hours	Min.	(Month, Day, 2/28/1	, Year) 918	WV	ntry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locat	ion					T	10d, Inside City Limits
	Maryl -f sho	to	WV Preston		Terra	a A1t	а						1 ☐ Yes 2 🖾 No
	h the	irec	10e. Street and Number				10f. Zip Code			1	0g. Citize	n of What Cou	ntry?
	23e c	Funeral Director	RR # Box 170				26764				US	A	
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. Wa	s Decedent of Hes, specify Cuba	lisp <i>a</i> nic Orig an, Mexican	gin? (Spec	cify Yes or No- Rican, etc.)	14	Race - Americ	
36	within 72 hours after death with the Maryland ane. then "neturel", or items 23e or 28e-f show he Madical Exattiner must be notified at	by F	1 ☐ Never Married 2½ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No	1	Yes 21X No	Specify:			S	pecify: Whi	ite
Maryland 21215-0036	2 hou	ted !	15. Decedent's Ed	lucation	16a.	. Deceden	t's Usual Occup	pation			16b. Kind	of Business/In	
215	en "n	Completed	(Specify only highest gra	de completed) College (1-4or:	5+)	(Give kin life. DO	d of work done NOT use retired	during most d)	t of workin		T C	Army Ai	· · · · · · · · · · · · · · · · · · ·
2	filed wi Hygien Sther th		12	4	I	Lt. C	o1. (Re						er corp
and	ntal H ed oti	Be	17. Father's Name (First, Middle, Last) Worley Klet Form							(First, Middle, I ane Forn		umame)	
2	should nd Me mark matic	2	19a. Informant's Name/Relationship		19b	Mailing A	Address /Street			Route Number		Town State Zin	2 Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel; or items 23e or 28e-1 show any njury or other freumatic event, the Madical Extrator must be notified at ance.		Katherine Johnson	,	1		ox 170,				2676		, code,
Baltimore,	ss 1 a		20a. Method of Disposition	,	20b. Place o	of Dispositi	on (Name of ory or other place					tion - City or To	own, State
Ĕ	Page nent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		Jeffer	rson	Barrack	s ¦	5/4/2	2005	St.	Louis,	MO
3alt	permit. Departi Importi any inj		21. Signature of Funeral Service Licer	is de	Nation	121 _{22.} %	emeter;	ss of Facility	y + E	neral Ho			
	905 g a		23a. Part1. Enter the disease, or com	spear								₩V 2€	5764
			shock, of heart failure. List only Immediate Cause (Final	one cause on each li	ne.	not enter t	he mode of dyir	ng, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical-		disease or condition resulting in death)		Myocard a consequence		Infarct	ion				1	hour
Į	Examiner			Tacher	nic Card	·	opathy						ears
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence		opaciij					- 1	cars
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	ate be executed obysician and the burial-transit	ai Ex	rosatting in asatti) East	Due to (or as	a consequence	01):							
687	Attending Physicien: The law requires that the death certificate be executed rideath. cleath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be deteched for use as the burial-transit.	edicai		d									
Box (death certifica attending ph d for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							236	d. Date of delive	ery
	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a	2 ☐ Fetal death t time of death		topic pregnancy ther <i>(specify)</i> _	<i>y</i>				Month	Day Year
Q. O.	at the de d by the a etached	Physician/M	9 Unknown	9□ Unknown									
ŝ	ires that signed t	by	Part II. Other significent conditions of Gastrointestinal			in the unde	erlying cause giv	en in Part I.			_		he cause of death?
Š	w requir been si should	eted		, breedin	5								
Records,	has law	Completed	Renal failure				-			24a. Was a autops perforr	sy	24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
Vital	icien: Th certificate rector, pag		25. Was case referred to medical					GE Diago	of Dooth		2 ½ No	1 ☐ Yes	2□No
	ysicien: The is certificate hadirector, page	o Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ent 2□ER/Ou	utpatient	3□ DOA Oth	ac		e 5 ☐ Reside		Other (Specif	
0 _	ng Ph Iter th neral	Ju: T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju	ry 28b.	Time of Injury	28c. Injur Wor			8d. Describe ho			,,
Sio	tendil leath. Ior: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not b	1			M 1 🗆	Yes 2 □ N					
Division of	p if i	Certification:	4 Homicide determined	286. Place of in	ury - At home, fa c. <i>(Specify)</i>	arm, street	, factory, office		2	8f. Location (St City or Town	treet and I n, State)	Number or Rura	al Route Number,
_	To the Hospitel or within 24 hours afte To the Funerel Dii completely filled in	S C	29a. Certifier 1 X Certifying Ph	ysicien: To the best	of my knowledge	e death or	coursed at the tir	me date and	d place a	nd due to the ca	2115B(s) 21	nd manner as s	tated
	ne Ho ne Fur	ledical	(Check only 2 Medical Exar	niner: On the basis of and manner st	f examination an	nd/or inves	tigation, in my o	pinion, deat	th occurre	d at the time, d	ate and p	ace, and due to	the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier				29c. Licens	e number	, -, -	2	9d. Date s	signed (Month,	Day, Year)
)			111				1)() <	>5	5	4/23	/05	
			30. Name and address of tell on who					and M	т °	1550			
	Sta	ite	Thomas Johnson, M 31. Date filed (Month, Day, Year)		ar's Signature	reet	, Uakla	alld, M	ш 2	1550			
: :	Regist			0005	Voge Si	a di	and I						

			1 - For State Registrar	State of	Marylan	-	artment of F rtificate of				iene 20	05	5	38
	Physici	an	1. Decedent's Name (First, Middle	e, Last) Oomer Frey					2.	. Date of Deat Month	th Day	Year	3. Time of Dea	ath
	/Medic	al	4a. Facility Name (If not institution				4h Cihi Toura	u Lagation		PRIL		005	12:34a	М
	Examin	ier	CARROLL COUNTY		,		4b. City, Town, o		or Death		4c. County			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under	24 Hrs. 8.	. Date of Birth	CARR	9. Birth	place (State or Fo	oreign
	Director		111-24-8305	1□M 2⁄QF	75	Yrs.	Months Days	Hours	Min. F	Date of Birth (Month, Day, eb 14,	1930	Coui N⊇W	York	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Li	imits
	Maryl f sho	ŗo	Maryland Cari	വി				Hamps	tead				1 ☐ Yes 2 ∑	
	r 28a	lrec	10e. Street and Number				10f. Zip Code		14.	1	0g. Citizen of V	Vhat Cou	ntry?	
	15 wit	Funeral Director	2705 Overview	v Road				210	74		Ţ	JSA		
	tems	nue	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13.	Was Decedent of H	lispanic Ori an, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No- can, etc.)		e - Ameri k, White,	can Indian, etc.	
36	rs afte		1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	9		1 ☐ Yes 2💢 No	Specify:	:		Specify	: V	hite	
21215-0036	72 hours after death with the Maryland neturel', or items 23e or 28e-f show deal Examinational be conflisted at	Completed by	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation			16b. Kind of Bu	siness/lr	dustry	
218	withIn 7 lene. then "n	npie	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+)	(Give life.	kind of work done DO NOT use retire	d)	st of working		Sc	chool		
121	e filed wi al Hygien other th vent, the		47 Fallanda Nama (Class Addulla	6	··		Teache:							
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Exporter must be notified at any injury or other treumatic event, the Medical Exporter must be notified at any injury.	o Be	17. Father's Name (First, Middle, Reuben Holmes	•						First, Middle, I Smith	Maiden Sumam I	9)		
ary	2 should be and Mental Is marked reumatic ev	Ţ.	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street					State, Ziş	Code) 210	40
Š	is 1 and 2 of Health a Item 27 is other trei		Richard Ohnmac	cht, son		2941	Excelsi	or Sp	rings	Ct, El	licott	City	, MD ²¹⁰⁴	ŧΖ
Baltimore,	Pages 1		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 Removal from S	itate c	emetery, cre	sition (Name of matory or other plac		Date		20c. Location -			
III III	it. Par rtmen rtent: njury		`4 □Donation 5 □Other (S	pecify)			Cremati		04/14/		Hampst		MD	
Ba	permit. Pages Department of I Importent: If Ite any injury or of once.		21. Signature of Funeral Service	Licensee	M00723	18	2. Name and Addre		L LI		neral Ho tead. ML		74	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death	h. Do not ent							Approximate Interval Between	n
	Physician		Immediate Cause (Final disease or condition	only one odder on ou	In	nak	e IN	Lale	An				Onset and Deat	
	/Medical Examiner		resulting in death)	Due to (c	or as a conseq	uence of):			1 507	~				
		-	Sequentially list conditions,	b. Due to (c	or as a conseq	uence of):						-		
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S										
ó	e be executed sician and s burial-transit		resulting in death) Last	C. Due to (d	or as a conseq	uence of):								
8760,	at ph	Physician/Medical		d								_		
9 X	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outo	ome of pregna	incv					22d Date	a of dollar	200	
Вох	death a atten d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1☐Live bii	th 2 ☐ Feta int at time of d	Ideath 3[Ectopic pregnancy Other (specify)	′			23d. Date Mor		Day Year	
P.O.	t the by th tache	hysl	9 Unknown	9□ Unkno	wn									
		by P	Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the u	nderlying cause giv	en in Part I.		_	_		ne cause of death	
ord	law requires as been sign 2 should be	eted								1 ∐ Ye	s 2□No	3 Prob	pably 4 Onkn	own
Vital Records,	0 5 0	Completed								24a. Was ar autops perforn	у р	Vere auto rior to coi eath?	psy findings avail mpletion of cause	able of
Ta Ta		e Co	25. Was case referred to medica	1				26 Place	of Dooth (C		No 1		2□ No	
	Physician: this certific ral director,	To B	examiner? 1 XYes 2 ☐ No	Hospital:	patient 2/7	ER/Outpatier	nt 3 DOA Oth	or.			e) ance 6 ∏Othe	er (Specif	iv)	
n of			27. Manner of Death 1 Natural 5 Pendin	28a. Date of		28b. Time of Injury					w injury occurre		1	
Sio	Attending r death. sctor: After y the fune	catle	Ccident investig	gation 4/12	105	2330	M 10	Yes 2		ictim	of ho	use	tive	
	I or Attendater deatl Director: I in by the	Certification:	4 Homicide determ	200, Tace	Injury - At ho g, etc. (Specifi	A A	eet, factory, office		281	City or Town	State)	r or Rura	Route Number,	7//
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by		29a Cartilor 1 Certifyin	g Physician: To the t	best of my kno	wiedge, deati	o occurred at the th	na, date an	nd place, and	due to the ca	Luss(s) and man	mer as s	lated.	14
	he Ho in 24 I he Fu pletely	edical	(Check only 2 X Medical one)	Examiner: On the baard mann	sis of examina	tion and/or in	vestigation, in my o	pinion, dea	ith occurred	at the time, da	ate and place, a	nd due to	the cause(s)	
		Σ	29b. Signature and little of certifie				29c. Licens			29	9d. Date signed			
•	MSL		More	au)			OC	ME		A	PRIL 1	3, 2	005	
	6	19	30. Name and address of person	who completed cause	of death (Item	1 23a) (Type,		enn S	treet	Balti	more M	larv1	and 2120	01
	Sta		31. Date filed (Month, Day, Year)		giatrar's Signa	ture					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			71
b	Registr	ar	APR 1	9 2005	Elesus	K	Courte							

68760
Вох
P.O.
Records,
Vital
of
vision

RUTH DORORTHEA GILMORE

	•	For	artment of Health and Men tificate of Death	-	30						
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Ruth Dorothea Gilmore 4a. Facility Name (If not institution, give street and number)		Date of Death Month Day Year 3. Time of PRII 23 2005 10:5	М						
Funeral Director	4	St. Mary 's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 287-26-8684 1 □ M 2 F 70 Yrs.	Leonardtown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aus	St. Mary's Date of Birth Month, Day, Year) g. 12, 1934 St. Mary's 9. Birthplace (State of Country) Ohio	r Foreigi						
the Maryland 28a-f show	rector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland St. Mary's Lex 10e. Street and Number 10e. Street and Number	ington Park	10d. Inside Cit 1 ☐ Yes 10g. Citizen of What Country?							
NOTE, Maryland 21215-UU36 ges 1 and 2 should be liled within 72 hours after death with the Maryland tt of Heelih and Mental Hyglene. If item 27 is marked other then "natural", or Iteme 23a or 28a-f show or other treumatic event, the Madical Example of must be usefilled at	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	20653 Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 No Specify:	Yes or Non, etc.) 14. Race - American Indian, Black, White, etc. Specify: White							
21215-0036 led within 72 hours aff tyglene. her then "natural", or nt, the Medical Exam.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 (Give life. I College (1-4 or 5+) Custom	dent's Usual Occupation kind of work done during most of working DO NOT use retired er Service Represent								
Maryland 2121: id 2 should be tiled within id 2 should be tiled within th and Mental hygiene. 27 le marked other then " treumatic event, the Men	To Be	Gustav Oscar Sill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir									
Baltimore, Misses 1 and 2 permit. Pages 1 and 2 permit. Pages 1 and 2 leagh a permit. If tien 27 is any injury or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Septical Censes Edward N. Brinsfield, Jr. M00052 22 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Hollywood, MD 20636 20c. Location - City or Town, State DO5 Arlington, Virgini sfield Funeral Home, P. Leonardtown, MD 20650— spiratory arrest, Approximate Interval Betwoonset and Conset	A. 027							
68 / 60, illicate be executed g physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.									
Geath cer death cer e attendin	Physician/Medic		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day	Year						
ecords, P.O. Iaw requires that the deas been signed by the a	þ	Part II. Other significant conditions contributing to death but not resulting in the u									
∓ के कि	e Completed	25. Was case referred to medical		autopsy performed? death? 1 Yes 2 No 1 Yes 2 No	e autopsy findings available to completion of cause of h? Yes 2 No						
on of Jing Phys After this tuneral di	sation: To B	examiner? 1	Other: 4 Nursing Home Variable Variable Variable Variable	Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
Division To the Hospital or Attent within 24 hours alter death To the Funeral Director; completely tilled in by the	cai Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stress building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, and								
To the Hi within 24 To the Fi complete	Medical	29b. Signature and title of certifier where the control of the casts of examination and/of in and manner stated.	29c. License number	29d. Date signed (Month, Day, Year) $4 - 26 - 05$							
Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, MANOJ D PANWALA SHAH ASSOC CHARLOTT 31. Date filod (Month, Day, Year) 32. Registrar's Signature APR 2 7 2005	TE HALL MD 20622								

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar		of Marylar		artment of F		ind M		Reg. No. 2	00	in line	
Physicia /Medica	al .		SHUA	J.	AUER		1.5	2. Date of Dea Month APRIL	18, 200		3. Time of Death 9:05 A M		
Examine	er	4a. Facility Name (If not institution 17817 VINYARD L	ANE			4b. City, Town, o	LLE			MON	lc. County of Death MONTGOMERY		
Funeral Director		5. Social Security Number 130–16–7874	6. Sex 1∭ M 2□ F	7. Age (In yrs. 78		If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da May 1,	y, Year) 1926	9. Birth Cou Bel	nplace (State or Foreign untry) gium	
Fig. 10 and 2 should be filed within 72 hours after death with the Maryland of thealth and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, the Me Jidal Evant art must be notified at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10b. County Montgo 10e. Street and Number 17817 Vinyard L 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced 15. Decedent (Specify only highes	ane 12. Was Dec Agned Fi ed 14 Yes If Yes, Gi Year or I 's Education it grade completed)	Roce redent Ever in U orces? 2 □ No Arn bates: WW	ny 2		dispanic Orig an, Mexican, Specify:		10d. Inside City Limits 1				
dilu AIA be filed withi mial Hygiene. ed other than event, I.v.	Be	17. Father's Name (First, Middle, Henry Grauer		(1-4or 5+) -	CPA				(First, Middle,	CPA Maiden Suma	PA iden Sumame)		
pariffice, Maryla permit. Pages 1 and 2 should Department of Health and Men Imporant: if item 27 is marke any injury or other traumatic once.	To	Anne Grauer - W 20a. Method of Disposition 1 △Burial 2 □ Cremation 4 □ Donator 5 □ Other (S) 21. Signature of Fungral Service	ife 3 □Removal from	Ctato	17817 Place of Dispo cemetery, crer cklawn	Vinyard sition (Name of natory or other place Menorah l	Lane,	Roc Roc -/20,	or, City or Tow Mary 1 20c. Location Rockvi	Maryland 20855 Oc. Location - City or Town, State Rockville, Maryland CHAPELS, INC.			
Physician /Medical Examiner	Examiner	23a. Parl. Enter the Jibuse, or shick, or heart fillura. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. META Due to b. Due to c.	each line.	th. Do not ent CARCIN quence of):	70 ROCKV	ILLE P	IKE ;	ROCK V	LLLE, M	ID 20	Approximate Interval Between Onset and Death 2.2 MONTHS	
S, F.O. DOX 00/00 es that the death certificate be gned by the attending physicic be detached for use as the bu	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition	1 ☐ Live 4 ☐ Preg 9 ☐ Unkr	death but not res	al death 3 death 5	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year Displaced use contribute to the cause of death?				
has b	ompieted			D ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						/es 2 □ No an 24b ssy rmad? 2 ☑ No	. Were aut prior to co death?	B Probably 4 Unknown ere autopsy findings available for to completion of cause of sath?	
OI VICAL Physician: this certifical al director, p	ertification; To Be C	25. Was case referred to medical examiner? 1 Yes 2 No											
spita ours ours fillec	edicai Cert	(Check only 2 Medical	g Physician: To th Examiner: On the t	pasis of examina	owledge, deat	n occurred at the tir	ne, date and	d place,	and due to the	own, State) e cause(s) and manner as stated. e, date and place, and due to the cause(s)			
To the Hos within 24 h	Med	29b. Signature and title of certifie	uclu	e number			29d. Date sign	Date signed (Month, Day, Year) RIL 18, 2005					
Stat Registra	_	31. Date filed (Month, Day, Year)	.D., 1060	egistrar's Sign) KEN	ISING	GTON, MI	2089)5		

			For State Registrar	State of Maryl	•			lealth and Death	Ме	-	giene Reg. No	2000	15141			
			1. Decedent's Name (First, Middle, La	ist)					2.	Date of De	ath Da	y Year	3. Time of Death			
	Physici /Medic Examin	al	Hannah J. 4a. Facility Name (If not institution, giv		Green	4b. Cit	y, Town, or	Location of Dea		Month pril	20,		2:10 A M			
	Funeral			Sex 7. Age (In)	vrs. last birthday)	If Und	er 1 Year	Accident If Under 24 Hr Hours Mir	s. 8.	Date of Bir (Month, Da	rth av. Year)	Garre 9. Bi	ett rthplace (State or Foreign Jountry)			
	Director		215-48-9262	1□M 2덨F 95	Yrs.		Duyo	110010		ov. 8	-		Maryland			
	land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation							10d. Inside City Limits			
	Mary I sh	ţ	MD Ga	rrett			0ak]	and					1 ☐ Yes 2√⊋ No			
	th the	Funeral Director	10e. Street and Number			10f. Z	ip Code	GIIG			10g. Cit	tizen of What C	country?			
	23a ust b	le l	5601 Hutton Road	<u> </u>				21550				USA				
	er dez	nue	11. Marital Status	12. Was Decedent Ever i Amed Forces?	n U.S. 13. \	Was Dec f Yes, sp	edent of Hi ecity Cuba	ispanic Origin? (n, Mexican, Pu <i>e</i>	Specif rto Ric	y Yes or No an, etc.)	p-	14. Race - Am Black, Wh				
36	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be multiled at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		I □ Yes	2 ☑ No	Specify:				Specify: [Vhite			
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. Deced	lent's Us	ual Occupa	ation			16b. K	ind of Busines	s/Industry			
218	within 7 lene. than "n nu Med	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired	during most of we)	orking							
7	filed withi Hygiene. other than		47 February Winds Addulled a	2+		T	eache	r 18. Mother's Na	/5	Tinas Adiabatta			y Education			
Maryland		Be	17. Father's Name (First, Middle, Last		-11/			1.75	·	risi, middie	, Maider	,				
2	and Menial Is marks	ှင	Frank – 19a. Informant's Name/Relationship		allis 19b. Mailir	g Addre	ss (Street a	Harri and Number or F		oute Numb	er, City		Bowman Zip Code)			
	alth ar 27 Is r trau		Faye Hetrick/Dau	ghter	105	Man	or Dr	ive, Oa	kla	nd, M	d. 2	1550				
Baltimore,	ges 1 a t of Hea if item or othe		20a. Method of Disposition		b. Place of Dispo cemetery, cren	sition (N	ame of		Date			ocation - City o	r Town, State			
Ë	Pa int:		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	(b) G	arrett C	o. M	em. C	dns 4/	24/	2005	0ak	land, N	1d.			
Salt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licenses 22. Name and Address of Facility 32										nd St.			
_	0 □ = 0		23a. Part1. Enter the disease, or con	lications that squard the s				meral H				and, Mo	1. 21550 Approximate			
н			shock, or heart failure. List only	one cause on each line.	eath. Do not ent	er ure iix	ode or dym	g, such as cardio	ac or re	sspiratory a	iiiesi,		Interval Between Onset and Death			
	Physician /Medical		disease or condition resulting in death) a. Atherosclerotic cardiovascular disease or condition resulting in death)										3 wks			
	Examiner			Alzheime		e d	emen	tia					14 yrs			
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con												
	death certificate be executed to attending physician and of for use as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	205112222 26):											
8760,	be ex ician burial		rosuming in doubly cust	Due to (or as a con	sequence or):											
687	physicate s the	Physician/Medical	`	d												
Box (eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre								23d. Date of de	alivery			
	death ie atte ad for	icia	in the past 12 months? 1 ☐ Yes 2 🖾 No	1 ☐ Live birth 2 ☐ F		Other (pregnancy specify)					Month	Day Year			
P.0	at the de I by the stached	Phys	9 Unknown	9∐ Unknown												
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions					en in Part I.					to the cause of death?			
Ö	w requir been si should	etec	Hypertension													
of Vital Records,	o	Completed	24a. Was an autome performe									prior to death?	ulopsy findings available completion of cause of			
la	en: Th tificate tor, pag	e Co	25. Was case referred to medical	1 ☐ Yes 2 ☐ 26. Place of Death (Check only one)								XNo 1 Yes 2 No				
<u>></u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ 📉 O									5 ☐ Residence 6 🕉 Other (Specify) PCH				
	ding Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending							I. Describe						
sioi	Nttendin death. ctor: Afr y the fur	catic	2 Accident investigation	on l		М	10	Yes 2 □ No								
Division	or A	Certification;	3 Suicide 6 Could not to determined			eet, facto	ory, office		28f	Location (City or To	Street ar wn, State	nd Number or F e)	lural Route Number,			
	Hospita 4 hours Funeral	edical Co	(Check only 2 Medical Exa	hysicien: To the best of my miner: On the basis of exam												
	To the within 2 To the complet	Med	29b. Signature and the of certifier	and manner stated.		2	9c. License	e number		· T	29d. Da	te signed (Mon	th, Day, Year)			
	⊢≯⊢ŏ		> 1 Junild	I folk time	2		D30					-20-20				
			30. Name and address of person who	completed cause of death	Item 23a) (Type,	Print)										
		A	Donald R. Ri	chter, M.D.	1533		oria	1 Driv	e C	akla	nd,	MD 21	1550			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	L	all ?									

	State of Maryland / Department / Depart	rtment of Health and M 5-05 thicate of Death	lental Hygid	ene 3. No.2 0 0 5	15142						
Physician	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death							
/Medical	MARK JOHN GASIOREK		APRIL 2	26, 2005	10:26a [™]						
Examiner		4b. City, Town, or Location of Death ELKTON		4c. County of Deat CECIL							
Funeral Director	5. Social Security Number 155-54-2368 G. Sex T. Age (In yrs. last birthday) 46 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Jan 31		hplace (State or Foreign buntry) aware						
show start	10a. State 10b. County 10c. City, Town or Loc	eation			10d. Inside City Limits						
Ba-f s	MD Cecil Elkton				1∰ Yes 2 No						
vith the M or 28a-f	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?						
s 23e	2200 E. Main St.	21921		J.S.A.							
and 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. d other then "neturel", or items 23e or 28e-f show event, the Medical Exert the right of modified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No of Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2√√2 No Specify:	icity Yes of No- Rican, etc.)	14. Race - Ame Black, White Specify:							
72 hours aff	15. Decedent's Education 16a. Deced	ent's Usual Occupation	16	b. Kind of Business/							
	(Specify only highest grade completed) (Give I Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of workii O NOT use retired)	ng								
d 21215-00 filed within 72 ho Hygiene. Hydiene "neture ant, the Medical ant, the Medical e Completed	1 E1∈	ctronics Teshni			ics						
Earyland 2121 2 should be filed within and Mantal Hygiene. Is marked other then eumetic event. In M. To Be Comp	17. Father's Name (First, Middle, Last)	18. Mother's Name		,							
should and Men			ne Johr								
2 55 5 5		Address (Street and Number or Rura									
Te, M	20a. Method of Disposition Disposition	881 Turners Poi		c. Location - City or							
Baltimore, semit. Pages 1 ar Department of Hea mportent: If item my injury or othe unce.	1 ☐ Buriai 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kent Cr			Smyrna,							
Baltimore, I permit. Pages 1 and Department of Heal Importent: If item 2 eny injury or other since.	21. Signatur Luneral Servica Licens 22. Ga M00510	Name and Address of Facility 1ena Funeral Ho 8 West Cross St	ome of S	Stephen	L. Schaech						
1 Jan 1957	23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac o	r respiratory arrest	i,	Approximate Interval Between Onset and Death						
/Medical	disease or addition resulting in death) AFTERIOSCIEFOLIC Co	ardiovascular dise	ease								
Examiner	Due to (or as a consequence of):										
Jer Jer	Sequentially list conditions, if any, leading to immediate cause. Ent. Indexping Cause (Disease or injury)	Due to (or as a consequence of):									
oxecuted executed in and rial-transit Examiner	that initiated events	c									
8760, sate be executed hysician and the burial-transit dical Examin	resulting in death) Last Due to (or as a consequence of):										
icate be physicie s the burner adicat	d										
Box 6 auth certific attending p for use as	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			33d Date of deli	100						
ecords, P.O. Box 687 law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the pleted by Physiclan/Medic	1 Live birth 2 Fetal death 3 1 in the past 12 months? 4 Pregnant at time of death 5 9 Unknown		Month	te of delivery onth Day Year							
IS, P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?						
Cords w require been sig should b			1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Unknown						
~ 0 F 0 F			24a. Was an autopsy performed Yes 2	d? prior to c	topsy findings available completion of cause of						
Vital Fictor: The certificate rector, pag	25. Was case referred to medical examiner?	26. Place of Death	Check on one								
T his	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		ne 5 Residenc	e 6 K ther (Spec	ify)						
Division of t or Attending Physiater death after death. Director: After this I in by the funeral di ertification; TC	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how	injury occurred							
Vision Attending or death. ector: After by the fune ification	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	M 1 Yes 2 No	Rf Location (Street	et and Number or Rui	ral Davita Aliembar						
Division of the or Attending P is after death. The Director: After led in by the funeral of the funeral certification;	4 Homicide determined 286. Place of Injury - A home, farm, stree	et, ractory, office	City or Town, S	State)	rai noute Number,						
Hosp 14 hour Fune Fune Ical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)						
To the within 2 To the comple	29b. Signature and title of certifier	29c. License number		Date signed (Month							
	(Cortell)	OCME		APRIL 27,	2005						
	30. Name and address of person who completed cause of death (Item 23a) (Type, P	111 Penn Street	Baltimo	re, Maryl	and 21201						
State Registrar	31. Date filed (Month, Day, Year) MAY 0 4 2005	N s									

	1	For State Registrar			State o	of Maryla	and / Dep <i>Ce</i>		nt of H te of L			ental Hy	giene Rag. No	_ U U	5	15143
Bhusiaia	-	1. Decedent's N	lame (First, Mic	ddle, Last)							2	Date of Do	eath Da		ear_	3. Time of Death
Physician /Medica			Avery	Stra	ughn	Gordy					1	Apeil	17	, 20		3343
Examine	_	4a. Facility Name (If not institution, give street and number), 4b. City, Town, or Location of Sallsburg 4b. City, Town, or Location of Sallsburg									4c. County of Death			8		
Funeral Director		5. Social Securi 220-32	-1411	6. Sex	M 2□F	7. Age (In y	rs. last birthday Yrs.	Month:	Days	If Under Hours	24 Hrs. 8 Min.	B. Date of Bi (Month, D Aug.	av. Year)	1925	Birthpl Count M	
with the Maryland a or 28e-1 show		Usual Residence 10a. State MD	10b. Cou	nty Ceste	r	10c.	City, Town or t								10	od. Inside City Limits 1X Yes 2 □ No
the Mi	ecto	10e. Street and			-				ip Code				10g. Ci	tizen of Wha	at Count	try?
3a or	<u> </u>		itts St						1811				US			
O36	by Fur	_	us Married 2 Ned 4	farried	Armed Find 1 XYes If Yes, Gi	2 No F	Army	If Yes, sp	edent of Hi ecify Cuba 2 X No	ispanic Ori in, Mexicar Specify:	n, Puerto R	ify Yes or N ican, etc.)	0-	14. Race - Black, Specify:	White, 6	etc.
- C 100	Completed		15. Dece Specify only hig Secondary (0-1)		completed)	(1-4or 5+)	(Giv	e kind of v	use retired	during mos	st of working	9		and of Busin	ness/Ind	lustry
_ ~	Be	17. Father's Na	me (First, Midd									First, Middle		Sumame)		
ore, Maryland ss 1 and 2 should be file of Health and Mental Hy litem 27 is marked oth r other traumatic event	2	19a. Informant	's Name/Relati	onship (Typ				_		and Numb	er or Rural	Route Numi	ber, City			
	į.	Rache 20a. Method of	l Comle	еу		20	b. Place of Dis	osition (A	ame of	1	Ra.,	Ocear		ocation - Ci		
altimore, rmil. Pages 1 ar partment of Hea portent: If item y injury or othe	ı	1 🔀 Burial	2 Cremati		emoval from	State	cemetery, ci larylan				m. 4-	22-05	Hur	lock,	MD	
Baltimo		21. Signature	Serv Xeek	ice License	uba	A						e Bur Iin, M			eral	Home
Physician		Immediate Car disease or con	ndition	or complication on the complex of th	e cause on	- 1	leath. Do not e	nter the m	ode of dyin	g, such as	cardiac or	respiratory	arrest,		N	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in dea			Due to	4-	sequence of):	Com								undles
uted d ansit	Examiner	Sequentially list if any, leading cause. Enter Cause (Disease that initiated expenses the expenses that ex	e or injury	{			sequence of):									
	dical Exa	resulting in dea	ath) Last		Due to	(or as a con	sequence of):									
c 68 artificat ing phy	e e	IF FEMALE:														
the death certification by the attending tached for use as	by Physician/M	23b. Was dece		2	1 Live	utcome of pre birth 2 I F gnant at time nown	etal death	B⊟Ectopic B⊟ Other	pregnancy (specify)	/				23d. Date of Month		ry Day Year
rds, P.O.		Part II. Other s	ignificant con	ditions con	tributing to	death but not	resulting in the	underlying	g cause giv	ren in Part	1.					e cause of death?
If Records, The law requires the law seen signe page 2 should be considered.	Completed							<u></u>				per	s an opsy formed? 2 \(\sum \)	pride	or to cor ath?	osy findings available inpletion of cause of 2 No
Vital F sician: Th certificate	BeC	25. Was case		dical						26. Plac	e of Death	(Check only				
on of I	2	examiner? 1 Yes 27. Manner of 1 Natura	2 No Death I 5 □ Pe	nding	28a. Date	Inpatient e of Injury onth, Day Yea	2 ER/Outpat 28b. Time Injury	of	28c. Injur Wor	4 🗆 19	2	e 5 Res 8d. Describe				v)
Division of To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral d	Certification:	2 Accide 3 Suicid 4 Homic	de 6□Co	estigation juid not be termined	28e. Plac	ce of Injury - / ding, etc. (Sp	At home, farm, pecify)					8f. Location City or To	(Street a own, Stat	nd Number te)	or Rura	l Route Number,
To the Hospitel within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check on one)	1 Cert	ifying Physical Examin	ner: On the	basis of exar	knowledge, de mination and/or	investigati	on, in my o	pinion, de	ath occurre	d at the time	e, date an	nd place, an	d due to	the cause(s)
To the within To the compl	Me	29b. Signature	and title of ce	rtiner	11/1				29c. Licens	e number	50.		29d. Da	ate signed (Month,	Day, Year)
		•		The same	(ע -	2 2	101		4-	18-0	yo o	5
ET 241			address of per	odd.	mpleted ca	use of death	(ITEM 23a) (Typ 	LD (P.)	5,	40 3	255	alis6	201	MD	21	801
Sta Registr		31. Date filed		20 21	005 32.	Edgistrar's S	(Item 23a) (Typ (PB) w ignature	free	į,	, .			-)		, .	

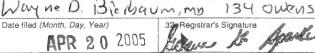
NVERY GORDY 330-32-1411

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend item #18 per inf g843 ertilicate of Death Reg. No. 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2:15 P M 2005 В. Gerran 14 Ernest April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges' Prince Georges' Cheverly Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1∭ M 2□ F 78 Yrs 217-22-4702 Director 21, NC Dec. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Montgomery Village Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20886 9533 Ash Hollow Place United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced R1 ack WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Exhibits Director 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest W. Gerran 2 Daisy DeLoatch DeLoatch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4679 Longstreet Lane #201, Alexandria, VA 22311 Michael A. Gerran/ Son Injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State April 20 2005 Parklawn Memorial Park ¹ 4 □Donation 5 □Other (Specify) Rockville, MD 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Liv Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician URDSEKIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Lijury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed -transit and resulting in death) Last Due to (or as a consequence of): burial-Records, P.O. Box 68760, attending physicien Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Cardiomyovathy 1 Yes 2 No 3 Probably 4 4 Honkhown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate Thorocic and orderent aneurysms 1 ☐ Yes 2 No ANTE 2 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After the Hospital or Attending 5 Pending 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funarel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D604366 Z 4/14/05 (0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyce CHEVERLY MD 20785 Co Hosp HOSPITAL DRIVE 31. Date filed (Month, Day, Year) 32 Registrar's Signature 1 9 2005 Registrar

			1 - For State Registrar	State of Ma	aryland / i		nent of H		Mental Hy	/giene Reg. No	400	5 1514
			1. Decedent's Name (First, Middle, Last,)					2. Date of D	eath		3. Time of Death
	Physici		Maclane	Ford	Gil	bson,		Sr.	April	Da 17	y Year 2005	0.20 m M
	/Medic Examir		4a. Facility Name (If not institution, give		<u>G1</u>			Location of De		4c	County of Death	9:30 p ™
			212 West Bay Fron	t Road				nian			Anne Ar	undel
	Funeral		5. Social Security Number 6. Sec	7. Ag	e (In yrs. last bi	Mo	Inder 1 Year nths Days	If Under 24 H Hours Mi		rth ay, Year)	9. Birth	place (State or Foreign intry)
	Director		319-20-0790 12		79	Yrs.			Feb 6			yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Location	n					10d. Inside City Limits
	Many 1 sh	ō	MD Anne Aru	ndel			Loth	ian				1 ☐ Yes 2 ☑ No
	28a-	Director	10e. Street and Number	IIGEL	1	10	f. Zip Code	Lall		10a, Cit	tizen of What Cou	intry?
	3a or		212 West Bay Fron	t Poad +			20711	1				,
	death ms 2	Funeral		12. Was Decedent	Ever in U.S.	13. Was ((Specify Yes or Neto Rican, etc.)	0-	USA 14. Race - Amer	ican Indian,
9	after or Ite		1 ☐ Never Married 2 X Married	Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give	No				erto Rican, etc.)		Bleck, White	, etc.
03	hours after death with the Maryland tural', or Items 23s or 28s-f show al Exertimer mast be notified at	l by	3 Widowed 4 Divorced	Year or Dates:	1946-48	1 1 1	es 2 No	Specify:			Specify: wh:	ite
21215-0036	72 na	Completed	15. Decedent's Edu (Specify only highest grad		16a	(Give kind	Usual Occup	during most of w	vorkina	16b. K	ind of Business/Ir	ndustry
7	within ene. than "	ldu.	Elementary/Secondary (0-12)	College (1-4or 5	·		DT use retired)				
2	e filed wall Hygiel other the		12 17. Father's Name (First, Middle, Last)		b	rick n	ason	40 M-45-1-N	In the Address of the		nstructi	ion
anc	buld be fi Mental H arked ot atic ever	Be		an Cile				_	ame (First, Middle			
Maryland	should be and Menta marked umatic ev	7	Joseph Lycurg			Mailing Ad	drace /Straat	Susan	Anne Rural Route Numb		Ford	n Code l
Ma	4 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Mary Jane Gibson,						Road, Lot	-		
ō,	Health Health tem 27 other tr		20a. Method of Disposition	spouse	20b. Place o	f Disposition	(Name of		Date Date		ocation - City or T	0711 own, State
Baltimore,	ages ant of it: If It		1 Burial 2 □ Cremation 3 □ P '4 □ Donation 5 □ Other (Specify)	lemoval from State			y`or other plac 'emeter	· 1	21-2005			
	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Fungral Service Licens	80	30.00		ne and Addres	4	21-2005	ТО	thian, M	Ш
Ba	Depa Impo any is		+ William	RKir	~				ome, P.A		Outings	MD 20711
F			23a. Part1. Enter the disease, or compl	cations tha caused	the death. Do						OWINGS,	Approximate
H	Physician		shock, or heart failure. List only or Immediate Cause (Final			14-3	£					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	••	lastoma a consequence		TOTTILE					
г	Examiner		On the Bullion of the second o									
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):						
	ecuter and trans	Examiner	that initiated events									
ő,	e executed a	Ä	resulting in death) Last	Due to (or as	a consequence	of):						
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	dlcal		l								
9	leath certific attending p	0	IF FEMALE:	3c. If yes, outcome	of programmy							
Вох	attene for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		pic pregnancy				23d. Date of deliv Month	ery Day Year
o.	the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or death	3 □ Othe	or (specify)					
۵.	The law requires that the de ite has been signed by the a page 2 should be detached	V Ph	Part II. Other significant conditions cor	tributing to death b	ut not resulting i	n the underly	ing cause give	en in Part I.	23e. Did	obacco u	use contribute to t	he cause of death?
Records,	puires n sign ald be	d by							1 🗆	Yes 2	No 3 □ Prot	bably 4 Unknown
CO	w requii been s should	Completed							24a. Was	an	24h Were auto	opsy findings available
Be	: The lav	ma								rmed?	prior to co death?	ompletion of cause of
Vital		a)	25. Was case referred to medical					26 Place of D	1 ☐ Yes eath Check onl	2 No	1 Tes	2□ No
		To B	examiner?	lospital:	nt 2□ER/Ou	utpatient 3	DOA Othe		Home 5 X Resi		6 ∏Other (Specia	(v)
of	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injur		Time of	28c. Injury Work	at	28d. Describe			,,
0	Attending in death.	atlo	1 Natural 5 Pending 2 Accident Investigation	(М		Yes 2 □ No				
Division	I or Attenc after death Director: I in by the I	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, fa	arm, street, fa	ctory, office		28f. Location (City or To		d Number or Rura	al Route Number,
Ω	oltal curs af											
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemination	ner: On the basis of	examination an	e, death occu nd/or investig	rred at the timation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as s place, and due to	itated. o the cause(s)
	thin 2 the the mple	Med	one) 29b. Signature and title of certifier	and manner sta	ited.		29c. License				e signed (Month,	
	\$ 7. <u>8</u> .7		1 marc	- M.DI	2m	mr						
			30. Name and address of person who co				D 317	/ 8	12	apri.	1 19, 20	05
1	5+1		Robert A. Miller,				Parkuz	v. Δnna	polis, M	J 2.	1401	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	s Signature			I Luna	POTTS, III	<i></i>	1 40 1	
	Registr	15	APR 2 (Magree .	B. L	parte					

Registrar

31. Date filed (Month, Day, Year) APR 20 2005



134 owens

ville

Rd, WEST River MD

20778

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear Physician PM HULL APRIL JANET S. 9:06 2005 15 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE SAWT HUSPITAL AGNES If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 25 F 87 Yrs. Director 185-05-7594 2/29/1917 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ∏Yes 217 No CATONSVILLE Md BALTIMORE Director 10f. Zin Code 10g. Citizen of What Country? 10e Street and Number 21228 USA 715 MAIDEN CHOICE LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. ADMINISTRATIVE ASSISTANT EDUCATION 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) laryland 12 should be fil and Mental H 7 Is marked otl Be CLARA MORELOCK HOWARD J. HULL traumatic 19a. Informant's Name/Relationship (Type, PrintSISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau 419 SYCAMORE ST., WESTMINSTER, MD. 21157 MILDRED C. BOLLINGER 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State . Method of Disposition

1 □ Burial 2 ▼ Cremation 3 □ Removal from State ↑ ↓ ↓ COUNTY CREMATION 4/18/05 SYKESVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CEREBRAC VASCULAR ACCIDENT WEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year o in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy 2 No certificate Division of Vital To the Hospitel or Attending Physicien: "within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 THomicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WIL D62023 APRIL 16, 2005 M.D.

Registrar DHMH 17 Rev 1/2001

State

6

AYODELE

31. Date filed (Month, Day, Year)

ORIGINAL

CATON

BALTIMORE

AVENUE,

MD 21229

900

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 9 2005

EMPLE, M.S.

			1- For Stata Ragistrar amend item	State of Mary				-	- / 1	105	15148
	Physicia		1. Decedent's Name (First, Middle, Last)		SEN			2. Date of De Month	aath Dav	Year 2065	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of I	Death		ty of Death	10.301
	Examin		Coastal Hospica	at the La	ake	Sali	shum	4	W	com	ico
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours		rth Year	9. Birthpla	ice (State or Foreign
	Director		058-20-3342	M 2 X F 80	Yrs.	Mortus Days	Hours	Min. 12/30/	1924	New S	
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	nantian.				1.0	
	shor	ž								10	d. Inside City Limits 1 ☐ Yes 2 XNo
	he M	Director	Maryland Wicomico	·			elmar)		45 000		
	with t		8809 Archid Drive	.		10f. Zip Code 21875	5		10g. Citizen of	What Count	ry?
	eath	eral		12. Was Decedent Ever	in II S 12			n? (Specify Yes or No	USA	ice - America	a ladion
36	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show edical Evaniner must be notified at	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	Specify:	Puerto Rican, etc.)		ack, White, e	tc.
Ö	hour turel'		3 Widowed 4 Divorced	Year or Dates:	160 Door	dost's Llevel Ossue	ation				
1 5	C 1 3	Completed	(Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most o	f working	16b. Kind of	Business/Indi	istry
12	within iene. than "i	Juc	Elementary/Secondary (0-12)	College (1-4or 5+)	House		,		Don	estic	
9	be filed withi ital Hygiene. id other than event.		17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle			
Maryland 21215-0036		To Be	Rudolph Buckholz				Lilli	ian Onder	donk		
ary	Sp. F. F.	-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailir	ng Address (Street a		or Rural Route Numb	er, City or Town	, State, Zip (Code)
	1 and 2 Health a em 27 is		Bernard H. Hansen/	husband	880	9 Archid	Dr. I	Delmar, MD	21875		
Je,	ges 1 a of tof He if item or other		20a. Method of Disposition	1	Ob. Place of Dispo			Date	20c. Location	- City or Tow	m, State
Ē	Pages nent of l int: If its		1 ☐ Burial 2 🖾 Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	y Cremato	· 1	4/19/05	Salisb	urv. M	ID .
Baltimore,	permit. Pag Department Importent: I any injury o once.	_	∠r ignature of Funeral Service License	90	22 H	Name and Addres	ss of Facility	L Home Pro			
	40 % & O		Varid It. Worry		FSP 5	01 Snow H	IIII Ro	l. Salisb	ury. MD	21804	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the secure cause on each line.	death. Do not ent	ter the mode of dying	g, such as ca	rdiac or respiratory a	rrest,		Approximate nterval Between Opset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Matesta	tic 15	recot	(ar	ncer			EVERUS
	/Medical Examiner		resulting in death)	Due to (or as a cor	rsequence of):						
		-	Sequentially list conditions, b	Due to (or as a cor	readilance of:						
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 43 4 661	isoquorioo oi).						
	xecu and al-tra	xar	that initiated events cresulting in death) Last	Due to (or as a cor	nsequence of):						
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical E									
687	ficate physics the	edic	0								
Вох	ath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pr					23d D	ate of deliven	,
ğ	d for	clai	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		Dectopic pregnancy Other (specify)					ay Year
0	the che	hys	9 Unknown	9⊡Unknown							
٣.	signed b	by P	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use cor	tribute to the	cause of death?
Records,	w requires been sign should be							10`	Yes 2 No	3 🗌 Probab	oly 4 □Unknown
O O	> 0 0	Completed						24a. Was		Were autops	y findings available
Re	0 2 0	mo							rringel?	death?	oletion of cause of
Vital	i icien : Th certificate rector, pag	0	25. Was case referred to medical				26 Place of	1 ☐ Yes Death (Check only of	2 No	1 Yes 2	Ø No
		O B	examiner?	ospital:	2 ER/Outpatien	nt 3 DOA Othe	NE.	ng Home 5 Resid		ner (Specify)	
οl	D 0 0	n: T	27 Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of	- Labrido	at	28d. Describe I			
<u>o</u>	Attending I r death. ector: After by the funer	atlo	Natural 5 Pending investigation	(Month, Say 100	ary mijury		res 2□No				
Division	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Num	ber or Rural I	Route Number,
	itel or line affine aff										
	To the Hospitel or Attendin, within 24 hours after death. To the Funerel Director: Aft completely filled in by the fun	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death mination and/or in	n occurred at the tim vestigation, in my op	e, date and pointion, death o	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as stat and due to ti	ed. ne cause(s)
	To t To t	×	29b. Signature and title of certifier	110	0.00	29c. License		76	29d. Date signe	ed (Month, Da	y, Year)
•	60		1000	well, V	VI	100	262	15	4-1	18-0	/
	2/4		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type.	Print)			,		
_	B		DAND BURL M) COASTAL;	HUSPICE A	10 C	34/73	3 Salis	L. R	(D) 21	1802

			1 - For State Registrar	State of M	1arylan		artment rtificate			and M	lental Hy	giene Reg. No.	2005	5 15149
ı	Physici		1. Decedent's Name (First, Middle, Las								2. Date of De Month	Day	Yea	3. Time of Death
1	/Medi Examir		4a. Facility Name (If not institution, give	street and number	r)		4b. City,	Town, or	Location o	f Death	04	26	200 County of De	
	Exami		University of Maryland	r /	rter		Bal	time					,	
	Funeral		5. Social Security Number 6. S			ast birthday) 71 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)		inhplace (State or Foreign Country)
	Director		Usual Residence of Decedent			71 Yrs.					Jun 3,	1933	3 <u>M</u> ;	aryland
	arylan show	_	10a. State 10b. County Maryland Freder	ick	10c. City	, Town or Lo	cation erick							10d. Inside City Limits
	the Ma	Director	10e, Street and Number	ICK		rred						40.000		1 X Yes 2 □ No
	3e or	i Dir	1421 Taney Aven	ue			10f. Zip	Code	21702	2			en of What (U.S.A.	Country?
	ems 2	Funerai	11. Marital Status	12. Was Deceden Armed Forces		S. 13. 1	Was Deced	ent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.))- 1	4. Race - An Black, Wi	nerican Indian,
36	72 hours after death with the Maryland Insturet, or Items 23e or 28a-f show died Executivet by notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Wivorced	1 Tes 2 If Yes, Give Year or Dates	(No		1 ☐ Yes 2		Specify:	, , , ,	riioari, oto.)		Specify:	White
90	72 hours "naturel",	Completed by	15. Decedent's Ed	ucation	· 	16a. Deced	dent's Usua	I Occupa	tion			16b. Kin	nd of Busines	
218	within 7 ene. then "n	nple	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	_	kind of wor DO NOT us		uring most	of worki	ng			•
121	e filed with Il Hygiene other thei vent, the l		8 17. Father's Name (First, Middle, Last)			Sea	mstre	SS	19 Motho	r's Name	(First, Middle			Manufacture
Maryland 21215-0036	d 2 should be filed within 72 hu th and Mental Hygiene. 7 Is marked other then "natu traumatic event, I'm Medical	To Be	Vernon		Etzle	er			Eth			ene	surrame)	Warner
Man	ith and traums		19a. Informant's Name/Relationship (7) Ralph R. Kolb, Ja								Andre Numb			zip Code) nd 21795
e,	es 1 and 2 of Health if item 27 I		20a. Method of Disposition			ace of Dispo	sition (Nam	e of	1		ate			or Town, State
imo	Pages ment of ent: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify							pr 2	29, 200	5 Tay	lorsv	ille, MD
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licen	Bern	M0070	22 06 1	Name and Keene 06 Ea	Address y & st C	Basfo Basfo hurch	rd F	P.A. Fu Frede	neral rick.	L Home Marv	land 21701
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each	ed the death line.	. Do not ente	er the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,	, , , , ,	Interval Between
)	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Cardio	1	nenery	(c11	apse						Onset and Death
	Examiner			Due to (or a	s a consequ	ience of): /	200	8						
Ļ	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ience of):								
V	icate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s 2 consocu	anon of):								
8760,	sician buria	dicai E		d	o a consequ	01/.								
9	tificate ig phy. as the	ledic		d										
). Box	the death certificate be executed y the attending physician and iched for use as the buriat-transit	Physician/Me	in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pre Other (spe					23	3d. Date of de Month	alivery Day Year
P.0	that the dead by the detached		9 ☐ Unknown Part II. Other significant conditions co	entributing to death	but not resu	Iting in the ur	derlying ca	use give	n in Part I		23e. Did to	obacco us	e contribute	to the cause of death?
ords,	law requires that as been signed b 2 should be deta	ted by												robably 4 Dunknown
Vital Records,	The ate ha	Completed							-		24a. Was autop perfo 1 Yes		24b. Were a prior to death?	autopsy findings available completion of cause of s 2 No
Vita	Physiclen: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Other	P4		Check onl			
of		1 €	27. Manner of Death	28a. Date of Inj	ury	R/Outpatient 28b. Time of		c. Injury	at INU		ne 5 🗌 Resid			ecify)
ion	Attending r death, sctor: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	М	Work?	7 es 2 □ N	io				
Division	I or Atten after deatl Director: I in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	jury - At hor tc. <i>(Specify)</i>	me, farm, stre	et, factory,	office		2	8f. Location (S City or Tox	Street and vn, State)	Number or F	lural Route Number,
_	Hospite 4 hours Funerel ely filled	edical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Examone)	rsician: To the best iner: On the basis of and manner si	of examinati	vledge, death on and/or inv	occurred a estigation, i	t the time	e, date and nion, death	place, a	nd due to the o	cause(s) a date and p	nd manner a place, and du	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Mon	th, Day, Year)
			and hollen	o Ins	>		A44	17642	5 ; bork	intel	5279	4	26	2005
	16		30. Name and address of person who c		death (Item		Print)				- ton /		- 4	2002
		to.	Jacod Berkow. +2 31. Date filed (Month, Day, Year)	22 S. 1	rar's Signati	M 2+	Bol.	mn	MD	21	201			
	Sta Registr		MAY 0 2	32. Regist	Luc.	K A	bark							
-								-		~				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 2005 Calvin Edward Hastings, Jr. April 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 219 Broad Street Worcester Berlin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10**X**M 2□ F Director 216-38-8310 63 May 9,1941 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Importent: If item 27 is marked of the then 'naturel', or items 23e or 28e-f show any injury or other treumetic event. The Modified Engine in must be notified as any injury or other treumetic event. The Modified Engine in must be notified as MD Worcester Berlin 1 □**X**es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Broad Street 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Calvin Edward Hastings, Sr. Marion Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lee Hastings-sister 219 Broad Street, Berlin, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Xurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 4/20/2005 Berlin, MD 21. Signature of Funer 22. Name and Address of Facility 108 William St. The Burbage Funeral Home Berlin, MD 21811 Durba 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Physician 1000 /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine inding physiclan and use as the burial-transit death certificate be executed Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Tyes 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} after Hospitel 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29h. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Michael P. Darnell MD 29 Broad Street, Berlin, MD egistrar's Signatu 31. Date filed (MontAPR 221) 2005 State Registrar

/Medi Examii	ian cal	Howard Ronal	:/) ld Harri	s			2. Date of Death Month		ear 1337
		4a. Facility Name (If not institution, give	street and number) +	4b. City, Town,	or Location of Dea	ith	4c. County of	
		5 802 Annagoli 5. Social Security Number 6. Se	s Koad	11/14	(Slade	r If Under 24 H		Prince	
Funeral Director		F-70 (((0(a	9X 7. A	ge (In yrs. last birthda) 56 Yrs.	Months Day			7 gar) 9	D. Birthplace (State or Country)
2		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				
f sho	ō	Md Prince	George	1	ensburg				10d. Inside City 1 ∑X es
r 28a-	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?
23a o usi be		5802 Annapolis	Rd #71	4	207	10		USA	
jiene. r than "natural", or itema 23a or 28a-i show the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes ŽÉ If Yes, Give Year or Dates:	t Ever in U.S. 13 ? No	i. Was Decedent of if Yes, specify Cu		Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. Black
ane. than "natur na Medical I	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	lucation de completed) College (1-4or	(Giv	edent's Usual Occi re kind of work don DO NDT use retir ashier	upation e during most of w red)	orking	6b. Kind of Busin	
lental Hygiene. ked other thas ic event, tha	To Be Co	12th 17. Father's Name (First, Middle, Last) Howard Lee H	arris				ame (First, Middle, Mi ache Park		
nt of Health and Mental Hyg		19a. Informant's Name/Relationship (7 MATHAN) Louise Hayhan	Гурв, Print) d-Aunt				Gural Route Number,		
nent of Health int: If Item 27 i		20a. Method of Disposition 1 Burial 2 Toremation 3 1 Donation 5 Other (Specify			position (Name of ematory or other pi			Oc. Location - Cit Riverd	
Department of He Important: If Iten any injury or oth once.		21. Signature of Funeral Service Licent	see Is		*\$\frac{1}{2} \text{*1} \text{*1} \text{*1} \text{*1} \text{*1} \text{*2} \text{*1} \text{*2} \text{*3} \text{*2} \text{*3} \text{*2} \text{*3} \text{*2} \text{*3} \text{*4} \text{*3} \text{*4} \text{*3} \t	uneral eorgia <i>P</i>	Home & C	Cremati Ashingt	on Servi
Medical and property the principle of th	al Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A there Due to (or as b. Due to (or as c.	s a consequence of): s a consequence of): s a consequence of):					Interval Betwonset and De
× 9	Medical	IF FEMALE:		2 Fetal death 3	☐Ectopic pregnan	су		23d. Date o Month	
attending p for use as	/usiclan/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	9□ Unknown						
igned by the attending p be detached for use as	ed by Physiclan/Me	in the past 12 months?		out not resulting in the		iven in Part I.		_	ite to the cause of dea
ate has been signed by the attending page 2 should be detached for use as	Completed by	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co		out not resulting in the			1 Yes 24a. Was an autopsy performs 1 Yes 25	2 No 3 Prio dea	Probably 4 Drawn re autopsy findings aver to completion of cau
ate has been signed by the attending page 2 should be detached for use as	Be Completed by	and the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions co	ontributing to death I		underlying cause g	26. Place of De	1 ☐ Yes 24a. Was an autopsy perform 1 ☐ Yes 2€	24b. Wer prio dea	Probably 4 properties autopsy findings average relation of cauth? Yes 2 No
n. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	ontributing to death to death the d	ent 2 ☐ ER/Outpatie	underlying cause g	26. Place of Dether:	1 Yes 24a. Was an autopsy performs 1 Yes 25	24b. Wer prio dea 1 0	Probably 4 properties autopsy findings average relation of cauth? Yes 2 No
n. After this certificate has been signed by the attending F funeral director, page 2 should be detached for use as	Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	ontributing to death to death the second se	ent 2 ☐ ER/Outpatie	underlying cause g	26. Place of Dether: 4 \(\text{Nursing} \) Nursing at ork?	24a. Was an autopsy perform 1 Yes 25 ath (Check only one) Home 5 Residen 28d. Describe how	24b. Weingrio dea 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4 properties autopsy findings average relation of cauth? Yes 2 No
n. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpati 28a. Date of Inj (Month, Date of Inj building, e	ent 2 ER/Outpatie ury ay Year) 28b. Time Injury jury - At home, farm, s tc. (Specify) of my knowledge, dea of examination and/or i	underlying cause g ant 3 DOA C of 28c. In; W M 10 treet, factory, office	26. Place of Dether: 4 Nursing up at ork? Yes 2 No time, date and place opinion, death occ	24a. Was an autopsy performs 1 Yes 25 Path (Check only one) Home 5 Residen 28d. Describe how 28f. Location (Stre City or Town, e, and due to the cau	24b. Wein prior dea 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	re autopsy findings ay to completion of cauth? Yes 2 No Specify) or Rural Route Number as stated, due to the cause(s)
has been signed by the attending p ge 2 should be detached for use as	Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	Hospital: 1 Inpati 28a. Date of Inj (Month, Da) 28e. Place of In building, e	ent 2 ER/Outpatie ury ay Year) 28b. Time Injury jury - At home, farm, s tc. (Specify) of my knowledge, dea of examination and/or i	underlying cause g ant 3 DOA C of 28c. Inj W M 15 street, factory, office ath occurred at the nvestigation, in my 29c. Licer	26. Place of De ther: 4 Nursing uny at ork? Yes 2 No	24a. Was an autopsy performs 1 Yes 25 Path (Check only one) Home 5 Residen 28d. Describe how 28f. Location (Stre City or Town, e, and due to the cau	24b. Wein prior dea 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Month Samuel Palmer Hostetter April 2005 10:30 AM 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1850 Old Taneytown Road Westminster Carroll County If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. Months 1 □XM 2 □ F 202-14-4577 78 Yrs Director 30 1926 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or Iteme 23e or 28e-f show treumatic event, the Medical Examinator must be notified at Maryland Carroll County Westminster 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1850 Old Taneytown Road 21158 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1944— If Yes, Give 1047 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 1947 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be fited within 7: th and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) machinist manufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy Hostetter Nannie Elliot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 so to of Health an Dorothy E. Hostetter / wife 1850 Old Taneytown Road Westminster, Md. 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ott 1

Burial 2 □ Cremation 3 □ Removal from State April 30 * 4 ☐Donation 5 ☐ Other (Specify) Trinity Lutheran Cem. Taneytown, Maryland 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service Licensee 136 East Baltimore Street Taneytown, Md. 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepstocellular Carcinom? 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of): Examine as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medicai IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy j in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by pe 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed2 page 2 🗆 No 2 No Division of Vital 1 🗌 Yes 1 Ves Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Matural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 00059943 26,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+1 vestminster Suite 307 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

2005

			1 - For State Registrar		Maryland /	/ Depa		t of H	ealth a		ental Hyg		005	Con.	150
	9		Decedent's Name (First, Middle,	Last)			imour		- Out.		2. Date of Dea	th	000	3. Time of	Death
	Physicia /Medic		Richard R. Hur	-							April :	Day 15, 20	005	7:30	АМ
	Examin		4a. Facility Name (If not institution,	give street and num	ber)		4b. City,	Town, or	Location of	of Death		- 1	unty of Death	1	
			Holy Cross Hos						Spring				ntgomer	У	
	Funeral Director		231-03-5075	3. Sex 1 M 2 ☐ F	7. Age (In yrs. last 85	birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birth (Month, Day Feb. 22	Year) 19:	9. Birthp Coun Virg	lace (State o try) inia	r Foreign
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						1	0d. Inside Cit	ty Limits
	Mary f sho	ţo	D.C. N/A		Wash	ningt	on						ŀ	1X Yes	2 🗆 No
	r 28e	irec	10e. Street and Number				10f. Zip	Code			1	l0g. Citizer	of What Coun	try?	
	23e o	aiD	1725 Jackson S	Street, N	Е.		20	018				Unite	ed Stat	es	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or items 23e or 28e-f show eny injury or other treumetic event. The Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford d 1 \(\bar{\Delta} \) Yes If Yes, Give Year or Da	1945		Was Deced if Yes, spec		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: B1		
Maryland 21215-0036	72 hou	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	6a. Deced	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition furing most	t of working	ng	16b. Kind	of Business/Inc	lustry	
12	within ne. han *	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+)		ounta ounta)			II C	Corror		
2	filed v Hygie ther t	Co	17. Father's Name (First, Middle, L	4 (4 (a) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c		ACC	Ounca	116	18. Mothe	r's Name	(First, Middle,		Gover	nment	
aŭ	ld be ental ked o	To Be	William R. Hun	,							Ann Pet				
37	shoul nd Mi marl	1	19a. Informant's Name/Relationshi	p (Type, Print)	1	9b. Mailir	ng Address	(Street a			Route Number		own, State, Zip	Code)	10
ž	alth a alth a 27 is		William A. Hurt	., Jr. (ne	ephew)	1725	Jack	son	St. N	ν.Ε.,	Washin	gton	D.C.	20018	
J.G	of He of He of He of He of He		20a. Method of Disposition	V. O	20b. Place ceme	of Dispo	sition (Nan	e of her place	9)	Da	ate	20c. Locat	ion - City or To	wn, State	
Ĕ	Page nent ent: II		1 ☐ Burial 2 ☐ Cremation : 1 ☐ Donation 5 ☐ Other (Specific Control of Contr				Memor			4/22	/05	Roanc	ke, VA		
Baltimore,	epartr sport ny inj		21. Signature of Funeral Service L	/		M	. Name an	d Addres e Fu	s of Facility	Ser	vice				
_	20 E 9 9		undre	2 (romp	son		400 G	eorg	ia Av	re. N	.W. Wa		ton, D		0012
	Pnysician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on ea	neumonia or as a consequen		er the mode	or dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Bety Onset and D	veen
F	Examiner				n as a consequen	ce oi).									
ŧ	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	or as a consequen	ce of):									
8760,	icate be executed physician and s the burial-transit	cal	resulting in death) Last	Due to (d	or as a consequen	ce of):									
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burfat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live bir	ome of pregnancy th 2 Petal dea that time of death	ath 3 🗀	Ectopic pre Other (spe					23d	. Date of delive Month	•	ear
<u> </u>	res that igned by be deta	by Ph	Part II. Other significant condition	s contributing to dea	ath but not resultin	g in the u	nderlying ca	use give	n in Part I.		23e. Did tol	oacco use	contribute to th	e cause of de	eath?
rds	w requires been sig should bo	ed b	Metastatic Pro	state Can	icer						1 □ Y	es 2□N	o 3 Proba	ably 4X_U	nknown
Records,	The law re ate has bee page 2 sho	Completed			·						24a. Was a autops perform	v	death?	osy findings an pletion of ca	available luse of
Division of Vital	ding Physicien: The n	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on				
7	hysic this co	2	1 ☐ Yes 2 ZNo			'Outpatien			4 🗆 1401		e 5 Reside)	
N C	ding Phys	lon:	27. Manner of Death 1 Anatural 5 ☐ Pending	28a. Date of (Month	f Injury 281 n, Day Year)	b. Time of Injury		3c. Injury Work	?		8d. Describe ho	w injury oc	ccurred		
Sic	or Attending ifter death. Director: After in by the fune	icat	2 Accident investigated as Suicide 6 Could not	t be	of Injury - At home	form our	M		′es 2□N	-	8f. Location (St	root and N	umber or Pural	Pourta Mumb	nor .
<u>></u>	l or A after Direction by	Certification:	4 ☐ Homicide determin	buildin	g, etc. (Specify)	, iaim, sm	ooi, iaciory	Office		_	City or Town	, State)	uniber of Huran	NODIO INDITE	Jer,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	ledical C	29a. Certifier 1 X Certifying	Physician: To the t	pest of my knowled	dge, death	occurred a	at the tim	e, date and	d place, ar	nd due to the ca	ause(s) and	d manner as sta	ated.	
	thin 24	Medi	one) 29b. Signature and title of certifier	and manne	er stated.			License					gned (Month, L		
}	ID TI		111	1) 1	/		200		2261						
	10.		30. Name and address of person w	ho completed cause	of death (Item 23	a) (Tyna	Print)	.ر ر	4 4 U I.		A	hrit	15, 200		
			Alan R. Segal,		/ 1		/	ilve	r Spr	ing.	Maryla:	nd 2	0906		
	Sta Registr		31. Date filed (Month. Day, Year)	32 Re	gistrar's Signature		sale)		, - <u>F</u>	-03				·	

Physici	an	1. Decedent's Name (First, Middle, Last)	20.50			2. Date of Death	Day Year	3. Time of Deat
/Medic	al	Douglas W. Jan		4b. City, Town, or	Logation of Douth	itpul	4c. County of De	0350
Examin	ier	Prince Geor		Che.	Location of Death		Prince	
Funeral		5. Social Security Number 6. Security Number	7. Age (In yrs. last bin	thday) If Under 1 Year	If Under 24tHrs.	8. Date of Birth	9. B	inthplace (State or For
Funeral Director		578-14-7615	244 G 🗆 🗆	Yrs. Months Days	Hours Min.	(Month, Day,	1917 W	nthplace (State or For country) ash., DC
		Usual Residence of Decedent						.,
how	_	10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Lin 1 Yes 2 □
Sa-f s	cto	DC			Washingto			
"naturel", or items 23a or 28a-f show edical Examinar cust be notified at	Funeral Director	10e. Street and Number 203–62n		10f. Zip Code	20011	10	g. Citizen of What C	
s 23s	ral		la St., N.E.	20019	2001 1	-7.1/11-		d States
Item	nu	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Amed Forces? 1 ⊠Yes 2 ☐ No	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	Rican, etc.)	14. Race - Arr Black, Wh	ite, etc.
l'. or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify:	Black
ature	Completed by	15. Decedent's Edu	cation 16a.	Decedent's Usual Occupa	tion	1	l 6b. Kind of Busines	s/Industry
. E S	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done di life. DO NOT use retired)	uring most of workir	ng		
ar the	mo.	12th	001090 (1. 401 017)	Bindery	Operator	c	Gover	nment
Went, went	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
Venta	일	Richar	d Jameson			Jane An	n Young	
and Mental Hygiene. is marked other then aumatic event, the M.		19a. Informant's Name/Relationship (Ty	pe, Print) 19b	Mailing Address (Street a	nd Number or Rura	Route Number,	City or Town, State,	Zip Code)
Health em 27 ther tr		William C. James	son - Son 5	26 Oneida St	., N.E. V	Vash., D	C 20011	
of He fiten r oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R	cometer cometer	Disposition (Name of y, crematory or other place)	1	Oc. Location · City o	r Town, State
ant: I		'4 □Donation 5 □Other (Specify)	Ft. Li	ncoln Cemete	ery 4/25,	/2005	Brentwo	od, MD
Department of Health and Menial Hygiene. Important: If item 27 is marked other then "natur any injury or other traumatic event, the Mcdical once.		21. Signature of Funeral Service License	e H	22. Name and Address	s of Facility Ste	ewart Fu	neral Hom	e
2 = 8		NohuT. S	eword II	4001 Benr				20019
		23a. Part1. at ter the disease, or compli shock, of heart failure. List only or	ations that caused the death. Do not cause on each line.	not enter the mode of dying	, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
ysician		Immediate Car se (Final disease or condition	Prostat	E Cance	^			Onset and Deat
ledical		resulting in death)	Due to (or as a consequence					
aminer		Sequentially list conditions.),					
sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):				
and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	of):				1
sician and burial-transit	calE		bac to (or as a consequence	51).				
attending physician for use as the buria						-		
iding se as	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy				23d. Date of de	aliven
atten for u	cian	in the past 12 months?	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
y the ched	iysle	1 Yes 2 No 9 Unknown	9☐ Unknown	o Za o tillo: (opodaly)				
ned by the atter	by Ph	Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause give	n in Part I.	23e. Did toba	cco use contribute	to the cause of death
n sign						1 🗆 Yes	2 🗆 No 3 🗀 F	robably 4 Unkn
should	lete					24a. Was an	24b. Were a	utopsy findings avail
page 2	Completed					autopsy	prior to death?	completion of cause
certificate rector, pag	Ö	25. Was case referred to medical			26. Place of Death		2-No 1 □ Ye	s 2 No
is certific director,	To B	examinar?	lospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DQA Othe	-		ce 6 Other (Sp.	ecify)
두교		27. Manner of Death	28a. Date of Injury 28b. 1	Time of 28c. Injury		8d. Describe how		ocnyy
	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		es 2□No			
alter death. Director: A I in by the fi	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa	rm, street, factory, office	2	8f. Location (Stre	et and Number or F	Rural Route Number,
of in	Certification:	4 Nomicide	building, etc. (Specify)			City of Yown,	Siale)	
within 24 hours affer deat To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination an	, death occurred at the time	e, date and place, a	nd due to the cau	ise(s) and manner a	is stated.
within 24 hours To the Funerel completely filled	edical	one)	and manner stated.					
To	Σ	29b. Signature and title of certifier	11-4-	29c. License		I	d. Date signed (Mor	
		falvade 1	Musty Do	1700	55721	? /	April 19	7, 2005
	1	/			GP .			

DHMH 17 Rev 1/2001

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 4b per Dr., G843, 05/19/05dhb State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #4a per dr/wichd/Certificate of Death4-20-05/dls _{Reg. No.} 2 1 5 1 5 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year AR 10: 00M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pa
with the Maryland te or 28e-f show Lee notified at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD WICDMICO FRUITLAND 10c. City, Town or Location 10d. Inside City Limits
036 ours after death with the Marylar rel; or Items 23e or 28e-f show Examinat remail be indiffed at	10e. Street and Number 202 LESCIE STREET 10f. Zip Code 10g. Citizen of What Country? 218 26 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
15-0036 72 hours after d "neturel", or item felical Evaruar.	1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes, Siver Year or Dates: Armed Forces? 1 Yes, Specify: Black, White, etc. Specify: BLACK
Z1Z1 d within giene. r then the Me	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)
be fill be fill doth out of out	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hea Hea	SYLVIA JOHNSON SISTER 202-LESLIE ST. FRUITLAND, MD 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore, permit. Pages 1 at Department of Hea Importent: If item any injury or othe	21. Signature of Funeral Service Licensee 22. Name and Address of Facility BENNIE SMITH FIH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BENNIE SMITH FIH 22. Name and Address of Facility BENNIE SMITH FIH 22. Name And Address of Facility BENNIE SMITH FIH 23. Name And Address of Facility BENNIE SMITH FIH 24. Name And Address of Facility BENNIE SMITH FIH 25. Name And Address of Facility BENNIE SMITH FIH 26. Name And Address of Facility BENNIE SMITH FIH 27. Name And Address of Facility BENNIE SMITH FIH 28. Name And Address of Facility BENNIE SMITH FIH 29. Name And Address of Facility BENNIE SMITH FIH 29. Name And Address of Facility BENNIE SMITH FIH 21. Signature of Facility BENNIE SMITH FIH 21. Signature of Facility BENNIE SMITH FIH 22. Name And Address of Facility BENNIE SMITH FIH 24. SMITH FINANCE SMI
be executed We executed be executed burial-transit burial-transit al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of): By Pought Affective Disorber Due to (or as a consequence of):
O. Box 687 ne death certificate the attending phys hed for use as the ysiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown
al Records, The taw requires t cate has been signe page 2 should be Completed by	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
vision of Vital Re Attending Physician: The ir death. ector: After this certificate hiby the funeral director, page iffication; To Be Com	25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death Check only one) 1 Nursing Home 5 Nursing Home
in paging a	2 Accident 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Cothe Hospitel Within 24 hours a To the Funeral It completely filled Medical Ce	29a. Certiflier (Check only) one) 1. Certifling Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To vide	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
State Registrar	31. Date filed (Month, Day, Year) 32. Projector's Signature APR 2 0 2005 Marin & Specific Signature

			Please	Type or Print State of Ma					-		-	le.		
			1 - For Stata Registrar	State of Ma	rytaric		rtificate of l		iu Mentai n	Reg. N	000	E.	ICIEC	
	Physic	an	1. Decedent's Name (First, Middle, Las						2. Date of D	eath	-	Year	3. Time of Death	7
	/Medi	cal	GRANVIL LEON JON 4a. Facility Name (If not institution, give				4b. City, Town, or	Location of C	April	17		05	1830 M	-
	Exami	ier	Peninsula Regiona	1 Medica	16	inter	30.	1135414	/		11	com	ico	
	Funeral Director		5. Social Security Number 6. Se	7. Age	(In yrs. la 80	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of B March March	T5,	1925		lace (State or Foreign try) Yland	n
	ne Maryland 8a-f show	Director	10a. State 10b. County MD Worcester	:		Town or Lo						1	0d. Inside City Limits	
	ath with the 23e or 2 ust be no	ral Dire	1946 Cedar Hall F	Road			10f. Zip Code 21851			10g. C	itizen of Wh USA	at Cour	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or itams 23e or 28e-f show any injury or other traumatic event, Ite Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 □ No IYYes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	spanic Origin n, Mexican, F Specify:	? (Specify Yes or N Tuerto Rican, etc.)	0-	14. Race - Black, Specify:	White,	etc.	
Maryland 21215-0036	within 72 he iene. Iene. Ithan "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12))	(Give	dent's Usual Occupa kind of work done o DO NOT use retired anic	luring most of	working		Kind of Busi		dustry	
vland	buld be filed Mental Hyg arked other atic evant,	To Be C	17. Father's Name (First, Middle, Last) C. Thomas Jones					Leona	Name (First, Middle Poulson	, Maide	n <i>Sumame)</i>			_
Mar	d 2 sho th and th and 7 Is m traum		19a. Informant's Name/Relationship (7) Nevada Jones/ wife						r Rural Route Numb					
re.	s 1 an of Heal itam 2 othar		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of matory or other place		Date		ocation - Ci			
Baltimore,	Page ment c ant: If ury or		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State)		st Ba	ptist Cem	4/	21/2005				cy, MD	,
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	eee Um		22 1	Name and Addres	s of Facility H Ave.	olloway M Pocomoke	elso City	on Fun	era.	l Home,	
	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the cause on each fine a. Due to (or as a	E 1	nyo	er the mode of dying	. 1	diac or respiratory a	arrest,		9	Approximate Interval Between Onset and Death	-0
	Examiner	e	Sequentially list conditions, if any, leading to immediate	0	ONA	RY 1	ARTELY	DISE	ALE			1	loyvs	_
	Gecuted and I-transit	xamlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									1	
68760,	tificate be exe g physician a as the burial-i	ш	resulting in death) Last	Due to (or as a	conseque	ence of):							A M	
P.O. Box (The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the buria	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal	leath 3	Ectopic pregnancy Other (specify)				23d. Date of Month		ry Day Year	
S, P	es that igned b	by PI	Part II. Dther significant conditions co	ntributing to death but	not result	ing in the ur	nderlying cause give	n in Part I.	23e. Did	tobacco	use contribu	ute to th	e cause of death?	_
ord	v require been si should b	eted	HYPERTENSION						1 🗆	Yes 2	□ No 3	Proba	ably 4 Unknown	
Vital Records,		e Comple	HYPERLIPIDIMI ATRIAL FIBR						1 ☐ Yes	psy ormed? 2 X No	prio	r to con th?	osy findings available apletion of cause of 2 No	
Γ	S S	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 X E	R/Outpatien	t 3 DOA Othe		Death <i>Check onl</i>		6 □Other	(Specify)	
Division of	fing After fune	ation;]	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	- 4	8b. Time of Injury	28c. Injury Work	at ? ′es 2 □ No	28d. Describe					
Divis	tal or Atters after de al Diracto ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At hom (Specify)	e, farm, stre	eet, factory, office		28f. Location (City or To	Street al wn, State	nd Number (B)	or Rural	Route Number,	
	To the Hospital or Attenc within 24 hours after death To the Funaral Diractor: completely filled in by the:	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xaminatio	edge, death n and/or inv	occurred at the time restigation, in my op	e, date and pi inion, death c	ace, and due to the occurred at the time,	cause(s date an) and mann d place, and	er as sta I due to	ited. the cause(s)	
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier				29c. License	number 2520	2	29d. Da	te signed (A	Month. E	Day Year)	
C	H. 10+1		trakash R.	Dalal, M		23a) (Type, I			re Drive.	pal	lisbra	2 m	p 21804	-
	Sta Registr		31. Date filed (Month APR 200 2	005 32. Figistrar's	s Signatu	4 4	partes		, , , , , ,			- n		

DHMH 17 Rev 1/2001

			For State Registrar			f Marylar		artment of H			Re	g. No.	2005	15	157
	Physici /Medio	an al	1. Decedent's Nam	T	KING JR			45 6% 7		\mathbf{AP}^{N}	ate of Deat lonth RIL	Day 14	2005	3. Time of 6:35	P M
	Examir Funeral Director			GEORGE S	give street and nur HOSPITA S. Sex 1 ★ M 2 □ F		last birthday) Yrs.	4b. City, Town, or CHEV If Under 1 Year Months Days	/ERLY	24 Hrs. 8. D.	ate of Birth Month, Day, nuary	PRII	NCE GEO 9. Birth Cou		r Foreign
	D.		Usual Residence o	of Decedent	GEORGE'S	10c. Ci	ty, Town or Lo	ocation	1,		nuur y			10d. Inside Ci	ty Limits
	h with the Mar 3e or 28a-f st at be notified	Funeral Director	MD 10e. Street and Nu 500 N.	ımber	. TRUMAN			10f. Zip Code 20774			10	17	n of What Cou	1 🔀 Yes	2 🗆 No
9003	d within 72 hours after death with the Maryland jene. Ir than "natural", or Itams 23e or 28e-f show Ire Macical Exaciliner out the institled at	þ	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	ried 2 Marrie 4 XDivorced	Armed For 1 XYes If Yes, Giv Year or D	² □No N a	ıvy	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No dent's Usual Occup	Specify:	gin? (Specify Y , Puerto Rican		Sp	Race - Ameri Black, White, pecify:	etc. BLACK	
Maryland 21215-0036	d within 72 jiene. ir than "na	Completed	(Spe Elementary/Sec 9th	cify only highest	grade completed) College (1	-4or 5+)	(Give	kind of work done of DO NOT use retired	durina most	of working			ERNMEN.	,	
yland	s 1 and 2 should be filed if Health and Mental Hygi itam 27 is marked other other traumatic avant.	To Be C	17. Father's Name		ast) R.				18. Mother	r's Name <i>(Fir</i> s OLIA G	t, Middle, A		imame)		
	is 1 and 2 sho of Health and itam 27 is my other traum		19a. Informant's N	KING/SO				JEFFERSO							202
altimore,	Pages 1 a ment of Hes ant: If itam ury or othe				3 □Removal from ecify)	State	cemetery, cre	osition (Name of matory or other place E CREMATO		Date 4/22/05			tion - City or T)
Balt	permit. Pages Department of Important: If i any injury or any once.		21. Signature of F	uneral Service L	censee		- 1	2. Name and Addres		J. D.			FUNERA LAND	L HOME 20785	
	Physician /Medical Examiner	iner	23a. Part1. Enter shock, or he Immediate Cause disease or condition resulting in death) Sequentially list confirm, leading to it cause. Enter Und Cause (Disease or Cause (Disease (Di	an failure. List of (Final on	a. Co Due to	ach line.	Artery	er the mode of dying Insuffic			piratory arre	est,		Approximate Interval Beth Onset and D	veen
x 68760,	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical Examine	Cause (Disease of that initiated event resulting in death)	is I	d	(or as a consec									
.O. Box		yslclan/	23b. Was deceded in the past 12 1 Yes 2 9 Unknow	2 months?		irth 2 ☐ Feta ant at time of c	al death 3	Ectopic pregnancy Other (specify)				230	I. Date of deliv Month	,	'ear
<u>a</u>	w requires that the been signed by th should be detache	by					•	nderlying cause given ted ingui				acco use	contribute to t	he cause of di bably 4∑∏U	
of Vital Records,	The law ate has b page 2 sl	Completed									4a. Was ar autops perform Yes 2	red?	24b. Were auto prior to co death? 1 X Yes	mpletion of ca	available ause of
Division of Vita	Attending Physicien: 1 r death. r death. sector: After this certifical by the funeral director, p	cation; To Be	25. Was case referenced a reference oxaminer? 1 Yes 2 2 2 2 2 2 3 2 3 2 3 2 3 2 3 2 3 2 3	XNo ath 5 Pending investiga	28a. Date (Mon.	·	ER/Outpaties 28b. Time o Injury	f 28c. Injun Worl	er: 4 □ Nur y at			nce 6		fy)	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	I Certification;	3 Suicide 4 Homicide		ned 286. Place buildi	ng, etc. (Speci	fy)	reet, factory, office	an date as	<i>C</i>	ity or Town	, State)	Jumber or Run		ber,
	To the Hos within 24 ho To the Fun completely 8	Medical	(Check only one) 29b. Signature an	2 Medical E	xaminer: On the b			vestigation, in my o	pinion, deat		the time, da	ite and pla		o the cause(s)	
)	(7)		1/	Lugar)		M.D.	- 00 \ =	Doo	5 %	188			18/05		
	49		maya	da I 550		001 Hos	pital	Print) Dr. Cheve	rly,	Marylan	nd 207	785			
	Sta Registi	-	APR 2 1	2005	Bleen 32. A	legistrar's Sign	ature								

			State of Maryland / Department of Health and Mental Hygiene
			1 - State Registrar Certificate of Death Reg. No. 2005 5 5 5
	Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
	/Medic	al	DOVOTNY LOUISE KTEIS HOLLING 19 205 12 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cigunty of Death
	Examin	er	4a. Facility Name (If not instifution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. KeS. 116
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth 24 F 88 Yrs. 4 North Days Hours Min. Feb 197, 1917 Mary Land
	Director		1241 / 200200
	pug A	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Maryli 4 sho	ō	MD Howard Ellicott City 1□Yes 2\\ No
	ith the Marylan or 28a-f show	rect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	h with	Funeral Director	5354 Briar Oak Court 21043 United States
	ems ems	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	s afte	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2√2 No If Yes, Give 1 □ Yes 2√2 No Specify: Specify: White
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examiner must be radilled at	edt	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
215	hin 72 s. sn "ng Med i	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life, DO NOT use retired)
	ad with	Completed	7 Homemaker Own Home
Maryland	12 should be filed within 7 n and Mental Hygiene. 7 Is marked other then " fraumatic event, the Mad	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard E. Seicke Clara L. Ammenheuser
<u> </u>	hould d Mer marke matic	유	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
M	nd 2 s lith an 27 Is i		Dorothy M. Bellomo/Daughter 5354 Briar Oak Court Ellicott City, MD 21043
e,	s 1 ar if Hea item		20a. Method of Disposition
E	Page nent c ent: If ury or		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 4-22-2005 Baltimore, MD
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Deportment of Health and Mental Hygiene. Importent: If item 27 Is marked other then "natural; or items 23s or 28a-f show any njury or other traumatic event, the Madical Examinet: wat be recillised at once.		21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043
	100		23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between
	Physician		Immediate Cause (Final disease or condition Congestive Heart tailuve Onse; and Death Vears
7	/Medical		resulting in death) Due to (or as a consequence of):
4	Examiner	L.	Sequentially list conditions, b. Valvular neart alsease years
	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
	sician and burial-transit	Examiner	that initiated events consequence of):
8760	death certificate be execul ee attending physician and ed for use as the burial-trar	dicai	d
9	rtifical ng phy s as th	Medi	IF FEMALE:
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 more set 12
0	the a	ysic	1 Yes 2 No 9 Unknown 9 Unknown
٥.	that the de led by the detached		Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds	w requires that been signed be should be det	q pa	atrial fibrillation Sick Sinussyndrome 10 Yes 20 THO 3 Probably 4 Unknown
Records,	law rec as bee 2 shou	Completed by	hypothyroidism, depression, depentia 24a. Was an autopsy findings available prior to completion of cause of
Re	The la	mo	performed? 1 Yes 2 No
Vital	ician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?
of \	shys this	10	1 ☐ Yes 2 PNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Proving Home 5 ☐ Residence 6 ☐ Other (Specify)
no	Jing After fune	tion	1 ⊕Natural 5 □ Pending (Month, Day Year) Injury Work?
Division	Attending r death. ector: After y the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
Ö	s after s after Director	Certification:	4 ☐ Homicide determined building, etc. '(Specify) City or Town, State)
	To the Hospital or Attencylinin 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To To To the Comple	Me	29b. Signature and title of dentitier 29c. License number 29d. Date signed (Month, Day, Year)
			Mill 4h MD 00058137 4/19/05
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
			31. Date filed (Monting Paray and) 32. Registrar's Signature
	Sta Regist		31. Date filed (MontifAPRY 2) 1 2005 32. Resistrar's Signature

			1 - For State Registrar	State of N	Maryland / De	partmen ertificate					giene	2000	15150
		in i	1. Decedent's Name (First, Middle, Last)	-					Date of Dea	ath		3. Time of Death
П	Physici /Media		Letitia Anne Kla	ckner						Month Oril	18 ^{Day}	y Year 2005	6:45 P M
>	Examir		4a. Facility Name (If not institution, give					Location o			4c.	County of Dea	
			Frederick Memori				deri	ck			F	rederic	k
	Funeral Director		3 - 1 3 1 3 1 3 1	х]м 2√ДF	Age (In yrs. last birthd 63 Yrs	Months	1 Year Days	If Under 2 Hours	Min. Au	Date of Birtl (Month, Day 1g • 26	h v, Year)	9. Bir 941 I11	thplace (State or Foreigr ountry) inois
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							Later
	Aaryla I sho	ō	Frederick Frederi	c k	Freder								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-i	ect	10e. Street and Number		rreder	10f. Zip	Codo				10- 04		
	with with	Funeral Director	136-138 West Secon	d Street		10i. Zip	2170	01				izen of What Co	ountry?
	ns 2%	era	11. Marital Status	12. Was Deceder	at Ever in U.S. 1	3. Was Deced			pin? (Specify	Yes or No-		14. Race - Ame	arican Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic avent, the Modical Examinar must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	PNo	3. Was Deced If Yes, spec	37	Specify:	, Puerto Rica	an, etc.)		Black, Whit	
ğ	2 hou	ted	15. Decedent's Edu		16a. De	cedent's Usua	I Occupa	tion			16b. Ki	nd of Business	
215	hin 7:	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4o	(G	ive kind of wor e. DO NOT us	k done d e retired)	uring most	of working				
2	d with	EO	Elementary/decondary (0°12)	4		Antique	e Dea	aler				Antique	es
<u> </u>	be filed ital Hygie d other avent, III	Be	17. Father's Name (First, Middle, Last)						r's Name (Fir			Sumame)	
<u>ā</u>	should be filed within and Mental Hygiene. s marked other than "umatic avent, IDE MA.	70	Owen Edwards					Doro	thy Ja	ne On	kin		
Maryland 21215-0036	nd 2 should alth and Mer 27 is marks ir traumatic		19a. Informant's Name/Relationship (T_y) Margaret L. Klackne		19b. Manter) 624	ailing Address Wilsor	(Street a	nd Number	r or Rural Ro Freder	ick,	r, <i>City</i> o Mar y	Town, State, 2	Zip Code) 1702
ë,	s 1 a of Hei itam itam		20a. Method of Disposition		20b. Place of Dis	sposition (Name	e of	1	Date		20c. Lo	cation - City or	Town, State
Ĕ	Page nent c		1 ☐ Burial 2 X Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from Stat	Smithsb				4/20/0	5 8	mith	sburg,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 It any Injury or other tra once.		21. Sign ture of Furlers Service Ligary	200	114	ROBERT	Address	S of Facility OATLE	Y & SO	N FUN	ERAI	HOMES,	P.A.
м			23a. Part1. Enter the disease, or compleshock, of heart failure. List enty of	cations that cause	the death. Do not	enter the mode	of dying	, such as o	CARDIAC OF res	• FKE.	DEKI est,	CK, MD	Approximate
. 1	Pnysician :	5	Immediate Cause (Final										Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a	s a consequence of):	rrudi	J-C	Pull	ne van	Di	3000	1.2.	Years
	Examiner				o a consequentes ety.				()			
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequence of):								
	cuted nd ransi	Examiner	if any, leading to immediate cause. Enter Underlying Cause Unit of that initiated events										
Ď,	an ar rrial-t	EX	resulting in death) Last	Due to (or a	s a consequence of):								
8/60,	cate be executed physician and the burial-transit	dical		1				,					
٥	death certifica	0	IF FEMALE:					_			-		
ŝ	ath ce ttendi	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom 1 ☐ Live birth		B⊟Ectopic pre	gnancy				2	3d. Date of deli	- /
T.C. BOX	the a	Physician/M	1 Yes 2 No	4☐Pregnant : 9☐ Unknown	at time of death	Other (spe	ecity)				ļ	Month	Day Year
	that the de led by the a detached t	Ph)	Part II. Other significant conditions cor	stributing to death	but not requiting is the			- in Do Al		00- Did 4-1			
Vital Records,	es peq	l by	Luna Cances		Dut not resulting in the	underlying ca	iuse givei	nın Panı.			es 2[the cause of death?
Ö	w requir been s should	etec	3									1140 0[]11	——————————————————————————————————————
ě	e law has l	Completed								24a. Was a autops	v	prior to c	topsy findings available completion of cause of
										perform	No	death?	2 No
=	siciar certif recto	Be	25. Was case referred to medical examiner?	lospital: 🚅.			Other		of Death (Ch				
5	Phys this ral dii	2	1 Yes 2 No 27. Manner of Death	28a. Date of Inj			1	4 U Nurs				Other (Spec	eify)
	tending Ph Jeath. tor: After th the funeral	E lo	1 Natural 5 ☐ Pending	(Month, D	ay Year) 200. Time		lc. Injury	es 2∐N	1	Describe ho	w injury	occurred	
2	I or Attending I after death. Diractor; After in by the funer	ica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a Place of Ir	niuny - At home form			63 2 14		ocation (St	root and	Mumbor or Ru	ral Route Number.
DIVISION OF	l or At after d Diract I in by	ertification;	4 Homicide determined	building, e	ijury - At home, farm, tc. (Specify)	street, ractory,	OHICE			City or Town		I Number or Hu	rai Houle Number,
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funeral Director. After this certifica completely filled in by the funeral director, it	edical C	29a. Certifier (Check only one) 1 Certifying Phys	1er: On the basis	t of my knowledge, de of examination and/or	ath occurred a investigation, i	t the time	e, date and nion, death	place, and d	lue to the ca	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	o the ithin ; o tha omple	Med	29b. Signature and title of certifier	and manner s	iai d u.		License					signed (Month	
	⊬ ≯ ⊢ ŏ) m To.	- iM(, _ = = 7, , \cdot \text{SEL} /
			30. Name and address of person who co				105	1610			7-	19-05	
	19		Michael Toli		1475 Tan		02	F-	edeni	ck	MO	. 7	1702
	Sta		31. Date filed (Month, Pay Year) 1 2		rar's Signature	Barren M.	F						1
	Registr	ar	HEL WIT		The state of								

			1 - For State Registrar	State o	of Maryland / De	epartment of H			jiene eg. No. 20	05 5 61
			Decedent's Name (First, Middle, L.	.ast)				2. Date of Dear	th	3. Time of Death A
	Physici /Medio		MARJORIE	BROCK	KATZEN	IBERGER		Month APRIL	Day 18 20	1001
	Examin		4a. Facility Name (If not institution, g				Location of Deat		4c. County	
			15320 PINE C	RCHARD	DRIVE	SILVER	SPRING		MONT	GOMERY
	Funeral Director		5. Social Security Number 6. 578-22-2018	Sex 1□M 2⊠F	7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day OCT 1	Year) 1921	Birthplace (State or Foreign Country) Texas
	p >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	- Landin				
	anyla ehov	_	A STATE OF THE STA	gomery		er Spring				10d. Inside City Limits 1 ☐ Yes 2 ► No
	Ne M	ecto								
	with t	Funeral Director	10e. Street and Number 15320 Pine Orc	hard Dri	.ve	10f. Zip Code	20906	1	Og. Citizen of V	What Country? d States
	Jeath The 2:	era	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-		e · American Indian,
21215-0036	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-f ehow any njury or other traumatic event, it e Medical Examinar in ust be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gir Year or D	2∰No ve	If Yes, specify Cuba 1 ☐ Yes 2 😿 No	n, Mexican, Puert Specify:	o Rican, etc.)		k, White, etc.
Š	2 hou	Completed	15. Decedent's	Education	16a. De	ecedent's Usual Occupa	ation		16b. Kind of Bu	usiness/Industry
215	thin 7 9. Med.	ple	(Specify only highest g Elementary/Secondary (0-12)	College (lis	Rive kind of work done d fe. DO NOT use retired	furing most of wor)	rking		•
2	ed wil	Con	12	2		omemaker			Own H	Home
Maryland	if be fill had had other	Be	17. Father's Name (First, Middle, Las Milton Brock	st)				ne (First, Middle, M	Maiden Sumam Mitese]	,
Ž	shoute nd Me mark imatic	To	19a. Informant's Name/Relationship	(Type, Print)	19b. M	lailing Address (Street a	Marga and Number or Ru			
Z.	and 2 alth a		Donald C. Katze			0401 Moxley		Damascus		20872
ore	OF HE TO		20a. Method of Disposition 1. ☑ Burial 2 ☐ Cremation 3	Domous from		sposition (Name of crematory or other place	9)	Date	20c. Location ·	City or Town, State
Ĕ	Pag ment ant: I		'4 □ Donation 5 □ Other (Spec			wn Cemetery	4/2	21/05	Rockvi	ille, Md.
Baltimore,	Depart Import any n		21. Signature of Funeral Service Lice	A B	as fee	22. Name and Addres Muriel I	s of Facility I. Barber 30x 5038	Funeral Laytons	Home	Md. 20882
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that of	aused the death. Do not	enter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
L	Priysician		Immediate Cause (Final disease or condition	,	Luna	Cancer				Onset and Death
	/Medical		resulting in death)	Due to	(or as a consequence of					7 700 (1)
П	Examiner		Sequentially list conditions.	b	Chronic	. Obstruc	Hive Pul	movered a	is evic	2 years
	bed salt	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence or):					-
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	cDue to	(or as a consequence of):					
38760,	icate be executed physician and the burial-transit	dlcalE		d						
-		യ :		V				MAR		
Box	death certifica attending ph of for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy birth 2 Petal death	3 ☐Ectopic pregnancy				e of delivery
O. E	the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown		ant at time of death	5 Other (specify)			Mor	nth Day Year
₾.	that the de ned by the a detached f		Part II. Other significant conditions	contributing to de	eath but not resulting in th	e underlying cause give	n in Part I	23e Did tob	acco use contri	ibute to the cause of death?
Records,	9 D 9	ted by			3	o underlying dudo give				3 Probably 4 Unknown
ec	e law r has be	Completed						24a. Was ar autopsy		Vere autopsy findings available rior to completion of cause of
E	ysiclan: The is certificate hidirector, page	Con						perform 1 ☐ Yes 2		eath? ☐ Yes 2 No
Vital	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		100		th Check onl one		
ot	Phys this al dir	P.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	npatient 2 ER/Outpa	tient 3 DOA	4 Nursing H	ome 5 Reside		
Division of	ding Phys	tion	1 Natural 5 ☐ Pending	(Mont	of Injury 28b. Time th, Day Year) Injur	ry Work	es 2 □ No	28d. Describe ho	w injury occurre	ag .
18	I or Attending Physiclan: after death. Director: After this certifics i in by the funeral director, i	ifica	3 Suicide 6 Could not	be 28e. Place	of Injury - At home, farm,					er or Rural Route Number,
	- 0	Certification:	4 Homicide determine	buildi	ng, etc." (Specify)			City or Town	. State)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying P	miner: On the ba	best of my knowledge, de asis of examination and/or ner stated.	eath occurred at the tim r investigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and man ite and place, a	nner as stated. nd due to the cause(s)
	To the l within 2 To the l	Me	29b. Signature and title of certifier	.1	1 2	29c. License	number	29	d. Date signed	(Month, Day, Year)
)	10		I Same	A Jack	5	D-39	140	F	toril 18	,2005
			30. Name and address of person who)832
	Stat	e	J. GARRETT REIL 31. Date filed (Month, Day, Year)				· · · · · · · · · · · · · · · · · · ·	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20	
	Registra		APR 192	005 Se	egistrar's Signature	28482				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/MEND#20b, cperFH4/25/05, BMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** YUNG DO April 8:21 P M 16 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 490.52.6063 Yrs. 68 Director 1936 Korea Usual Residence of Decedent the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a State Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Macteal Examiner must be notified at 1K Yes 2 No Rockville Director Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 U.S.A. 513 Rosebush Lane illed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Cartographer World Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fi Kye Young Sohn Yung Seo Koo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 siment of Health an 513 Rosebush Lane, Rockville, Maryland 20850 Hee Sue Koo/Wife 20b. Place of Disposition (Name of For Lincoln 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o Brentwood Baltimore, Maryland 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Loudon Park Crematory 04/20/2005 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. Nonce 11800 New Hampshire Ave, Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final arrythmia **Physician** minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** arken wonder minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ pe 4 Unknown 1 Yes 2 No 3 Probably Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 3□ DOA 10 1 Tes 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28c. Injury at Work? 27. Mannar of D 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 2 No death. 1 Tes after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai completely within 2 To the I and manner stated To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 05712 04/16 0) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Aaron Marc Snyder, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

APR 19 2005

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** P M April 16 2005 3:30 Christina Kovarcik /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Potomac Valley Nursing Home Rockville Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 15, 1910 New York, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 ☐ F 94 057-10-6927 Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State "natural", or Items 23a or 28a-f show sdical Examiner must be notified at 1 X Yes 2 □ No 01nev Montgomery Direct 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 20832 United States 19004 Willow Grove Road Funerai Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 f Yes, Give 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. Specify: If Yes, Give Year or Dates: White δ 3 ∰ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked r other traumatic e Stefan Gabris Anna Holic 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
important: if item 27 is
any injury or other trau 18 Hickman Drive, Hopewell Junction, NY 12533 John Kovarcik, Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1√Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Kensico Cemetery April 20, 2005 Valhalla, NY 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses (U) 11800 New Hampshire Avenue Silver Spring MD 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac arrythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial transit Cause (Disease or that initiated events ding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐ Yes 2 X No been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page this certificate 1 Yes 2 No Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 0 within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 18, 2005 D38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blvd, Suite 330, Rockville, MD 20850 A. Mendhiratta 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 9 2005 Registrar

ADH STEPHEN E. KUIPER 05-2665

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State	of Maryland /	Dep	artme	nt of	fΗ	lealth	and	Mental	Hygier
		-				_			

	- Registrar			
	1. Decedent's Nan	ne (First,	Middle,	Last)
n	Stanhan	E K	uin	ar

For

Certificate of Death

2. Date of Death

16,

Physicia /Medical Examiner

Stephen E. Kuiper 4a. Facility Name (If not institution, give street and number)

4b. City. Town, or Location of Death

Year 2005 A M 0442

Funeral Director

r than "natural", or Itams 23s or 28s-f show the Medical Example trust by notified at

other than

permit. Pages 1 and 2 should be 1 Department of Health and Mantal I Important: If item 27 Is marked of

injury or

any.

Physician /Medical

Examiner

physician and s the burial-tran

as the attending

use

has

After

in by t

within 24 hours after death To the Funeral Director:

page this certificate

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Direct

Funeral

ξ

Completed

Be

Examiner

Physiclan/Medical

þ

Completed

Be

Certification: To

Medical

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

HOWARD COUNTY GENERAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1**X** M 2□ F 25

COLUMBIA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

10f. Zip Code

4c. County of Death HOWARD

002-64-6114

Usual Residence of Decedent 10b. County

8. Date of Birth (Month, Day, Year) 7/27/1979

Month

APRIL

 Birthplace (State or Foreign Country) Massachusetts

10d. Inside City Limits

ty Yes 2 No

10a. State Maryland Anne Arundel

Crofton

10e. Street and Number

11 Marital Status

10c. City, Town or Location

10g. Citizen of What Country?

Specify:

1717 Fernham Court

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married

College (1-4or 5+)

21114 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black. White, etc.

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

1 ☐ Yes 21 No 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

White 16b. Kind of Business/Industry

Elementary/Secondary (0-12)

Salesperson

ADT Alarm

USA

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

Edward J. Kuiper

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Jevon Yandow

1717 Fernham Court Crofton, MD 21114

Jevon Yandow/ Mother

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

Huntt Crematory

Waldorf, MD 4/19/2005 22. Name and Address of Facility Robert E. Evans Funeral Home

21. Signature of Funeral Service Licensee

16000 Annapolis Road Bowie, MD 20715

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate the East of Jaying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal dea 2 Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day Year

4□Pregnant at time of death 9 Unknown

2 100

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

25. Was case referred to medical examiner?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

autopsy performed?

2 🗆 No

1 Tyes

24a. Was an

VZ Dres

1 X Yes 2 ☐ No 27. Manner of Death Natural 20 Accident

Suicide

30. Name and address of

4 Homicide

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Qay Year) 28b. Time of Monur, OUV 28e. Pisce of Injury · At hon building, etc. (Specify)

1 ☐ Yes 2 WNo

26. Place of Death (Check only one)

28d. Describe how injury occurred D2. VER OF CAR WHICH 572 VICE A Location (Street and Number or Rural Route Number, City or Town, State) 1 AT ROUTE

JESSUP, MD

(Check only

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of

29c. License number

111 Penn Street

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

erson who co

OCME

APRIL 16, 2005

31. Date filed (Month, Day, Year) State APR 18

My a RIPPLE 32. Registrar's Signature 2005

inpleted cause of death (Item 23a) (Type, Print)

MIGHWA

Registrar

			1 - State Registrar		artment of Health rtificate of Death	<u> </u>	Reg.	00	05	15161
	Physic	an	1. Decedent's Name (First, Middle, Last) Bessie C. Langf	e1d		2. Date Mor Apr	of Death	Day 14,	2005	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location				y of Death	7:05:A M
	Lxamii	ici	Hebrew Home of Greater Was	*	Rockville				gomer	У
	Funeral Director		5. Social Security Number 207-07-6435 C. Sex 1 M 2 7. A	ge (In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under Months Days Hours	Min. Aug.	of Birth hth, Day, Ye 22,	1914	9. Birthp Coun Penn	lace (State or Foreign try) sylvania
	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show incl. Ever. It with the rottlifted at	Funeral Director	10a. State 10b. County Maryland Montgomery 10e. Street and Number	10c. City, Town or Lo			10g.	Citizen of	What Coun	0d. Inside City Limits 1 Yes 2 □ No 1 No
	23a ust b	ral	6121 Montrose Road		20852		Uni	ted S	tates	of America
900	ours after des iral', or itams	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Deceden Armed Forces 1 □ Yes, Give Year or Dates	?]No	Nas Decedent of Hispanic Of Yes, specify Cuban, Mexical Of Yes 2 No Specify		or No-		ce - Americ ick, White, fy: Wh	
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life, L	dent's Usual Occupation kind of work done during mo DO NOT use retired) al Hygienist	est of working	16b		istry	lustry
land 2	ild be filed lental Hygi ked othar ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Samuel Chait			ner's Name <i>(First, I</i>				
nore, Mary	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene, ortant: If itam 27 is marked othar than "natural", or Itams 23a or 28a-f show injury or other traumatic event, the Medical Evantuer must be rectified at 8.		19a. Informant's Name/Relationship (Type, Print) Bruce Markowitz - Attorney 20a. Method of Disposition 1 Burial 2 Cremation 3 Memoval from State	20b. Place of Dispo	natory or other place)	East Tow Date	er, Su 20c.	uite . Location	1100 . - City or To	20005 wn, State
Baltimore,	permit. Page Department of Important: If any injury of once.		'4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee	22	Name and Address of Facility of Parish 2016 2017 Name and Address of Facility of Parish 2016 2017 Nockville	04/22/05 There Mem				n, Virginia
8760,	Physician pe executed was attending physician and per astending physician and dor use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	eimer s Dem s a consequence of): s a consequence of): s a consequence of):	entia					Interval Between Onset and Death
.O. Box 6	death certifi e attending d for use as	Physician/Medical		2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				te of deliver	y Day Year
٥.	quires that n signed b ıld be deta	by	Part II. Other significant conditions contributing to death Osteoporosis	but not resulting in the un	derlying cause given in Part	I. 23e	Did tobacc			e cause of death?
Vital Records,	 The law requires that the lcate has been signed by th r, page 2 should be detache 	Completed	Osteoarthritis				Was an autopsy performed?	?	prior to com death?	sy findings available pletion of cause of
of	nding Physician: The la ath. r: After this certificate has e funeral director, page 2	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 Xo Hospital: 1 Inpati 27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	ury 28b. Time of	Other					
Division	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of In building, e	jury - At home, farm, stre tc. (Specify)		City	or Town, Sta	a <i>t</i> e)		Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best 2 Medicel Exeminer: On the basis of and manner st and manne	of examination and/or inv	estigation, in my opinion, dea	nd place, and due t ath occurred at the	time, date a	ind place,	and due to t	the cause(s)
	T Too		29b. Signature and title of certifier	WD	29c. License number			_	d (Month, D	
	+		30. Name and address of person who completed cause of	death (Item 23a) (Type, F		ville, MD			14,	2005
	Sta Registr	_		rar's Signature		ville, MD	2003			

			For State Registrar		State	of Mar	yland /		artmen rtificate			and M		eg. No.	200	5 15	165
ı	Physici	an	1. Decedent's Name		ast) a Alice	Luck	.OW						2. Date of Dear Month April	Day 20	2005	3. Time (
	/Medic Examin		4a. Facility Name (# 1	not institution, g	ive street and	number)					Location o		11722	4c. C	ounty of De	ath	
Ī	Funeral Director		5. Social Security Nu 213 07 6	mber 6.	Sex 1 □ M 2 🔯 F	7. Age (In yrs. last	birthday) Yrs.	If Under Months		If Under		8. Date of Birth (Month, Day Sept 22		9. B	irthplace (State Sountry) aryland	or Foreign
	the Maryland 28a-f show	rector	Usual Residence of I 10a. State MD 10e. Street and Num	10b. County Howard	d	1	0с. Сіty, то		City				1	0a. Citize	on of What C		City Limits
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Manial Hyglene. Importent: If item 27 is marked other than *netural', or Items 23a or 28a-f show proportion of the record of the Walfall Exercipes India and once.	by Funeral Director	3000 N. I	Ridge Ro	12. Was D Armed 1 🔲 Ye If Yes,	ecedent Eve Forces? Is 2½ No Give r Dates:	er in U.S.	1		2104 dent of His cify Cubar		gin? (Sp	ecify Yes or No- Rican, etc.)	U	nited Race - Am Black, Wh	States	
21215-0036	əd within 72 ho rgiene. ar than "netur t, tre Medical	Completed	(Specification (Speci		rade complete Colleg	e (1-4or 5+)	10	(Give life.	dent's Usua kind of woi DO NOT us emake	rk done d se retired;	luring mosi)		ing	Ow	of Busines		
Maryland	should ba filed ind Mantal Hygi marked othar umatic event, I	To Be	John Dems	ski				Oh Maile	- A delega		Julia	a Ols				Zin Codo)	
	Pages 1 and 2 st nent of Health and int: If item 27 is n iry or othar traun		19a. Informant's Nar Gerri Gle 20a. Method of Dispo	enn/Daug	hter	om State	20b. Place	3113 of Dispo	Hear esition (Name matory or o	thst ne of ther place	one F	load		t Ci	Ly , M ation - City o	21042 or Town, State	
Baltimore,	permit. Pa Departmen Importent: eny injury once.		° 4 □ Donation State of Fundamental Signature of Fundamental State of F			the !	ніgh M0104						7-2005 Ty H. W Pike Ell				H Inc. 1043
	Pnysician /Medical Examiner		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List on inal	y one cause o	at caused the each lime ach lime to (or as a contract)	NEU	mo	er the mod		g, such as	cardiac	or respiratory arr	est,		Approxima Interval Be Onset and	etween
68760,		icai Examiner	Sequentially list con- if any, leading to immeause. Enter Under! Cause (Disease or in that initiated events resulting in death) La	hediate lying njury	C.	to (or as a c											
P.O. Box 68	ath certific ttending pl or use as t	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nenths?	1 □ Liv 4 □ Pr	outcome of re birth 2 egnant at tin	Fetel de	ath 3[Ectopic pr					23	d. Date of d Month	elivery Day	Year
Records, P.	w raquires that the de baen signed by the a should be detachad f	þ	Part II, Other signific	cant conditions	_ 7	death but	not resultin	g in the u	nderlying c	ause give	n in Part I.			oacco use		to the cause of	death?
al Rec	n: The law ficate has b r, page 2 st	Completed												ned? No	24b. Were a prior to death?		s available cause of
Division of Vital	Attending Physiclan: The laver death. ector: Atter this certificate has by the funeral director, page 2	ation: To Be	25. Was case referred examiner? 1 Yes 2 27. Man or of Death Natural 2 Accident	5 Pending investigat	28a. Da (A	□ Inpatient ate of Injury fonth, Day Y		Outpatier o. Time o Injury		8c. Injury Work	r: 4 Nu	rsing Ho	h (Check only on ome 5 ☐ Reside 28d. Describe ho	ence 6		ecify)	
Divis		Medical Certification:	3 Suicide 4 Homicide	6 Could not determine	d 289. Pi	ace of Injury illding, etc.	(Specify)						28f. Location (Si City or Town	n, State)			mber,
	To tha Hospital or within 24 hours after To the Funeral Dir completely fillad in	Medical	(Check only one)	2 ☐ Medical Ex	aminer: On th		xamination		vestigation		oinion, dea		and due to the cared at the time, d	ate and p	lace, and du		(s)
)	To To		29b. Signature and t	sueu	~ X	all	lai	N'		1 -	8(9	5	ots A		Α.		
			30. Name and addre	Em	CAK	ause of dea	1, 7	220	Print) PA	RK	HE	19	ots A.	E	BA	NMD	21204
	Sta Registi		ST. Date filed (MUNIT	APR		- 107	Sugnature .	K	Los	de							

1		1 - For State Registrar	State of Marylan		artment of		ind Mental	Hygiene Reg. No	4000	15166
Physic /Medi		1. Decedent's Name (First, Middle, Last) Darlington E. Lew	is				2. Date of Month	n Da		3. Time of Death 4:30 P
Exami	ner	4a. Facility Name (If not institution, give stella Maris 5. Social Security Number 6. Sex		last birthday)	Timon	ar If Under 2			Baltimo	
Director		Usual Residence of Decedent	^{1M 2□ F} 56	Yrs.	Months Da	ys Hours	Min. (Mont 05/0	of Birth h, Day, Year, 2/1948	8 Mary	land
h the Maryler r 28e-f show	Director	MD Harford 10e. Street and Number	10c. Cit	y, Town or Lo	erdeen	e		10g. Ci	itizen of What Cou	10d. Inside City Limits 1 Yes 2 □ No ntry?
is it is in the Maryland with the Maryland since. I within "netural", or items 23a or 28e-1 show the Madical Examinational be notified at	by Funeral	505 Plaza Court , 2 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Apt. 1A 12. Was Decedent Ever in U Armed Forces? 1 Yes, Give Yes, Give Year or Dates:		2100 Was Decedent of Yes, specify C	of Hispanic Orig Cuban, Mexican,	gin? (Specify Yes , Puerto Rican, etc	or No-	U.S.A. 14. Race - Americ Black, White, Specify: Bl.	
within 72 ane. than "nei	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12)		(Give	dent's Usual Oc kind of work do DO NOT use rel Pruck D	ne during most tired)	of working		Kind of Business/In	,
be filed that Hyge of othe event,	To Be Co	17. Father's Name (First, Middle, Last) Albert C. Lewis,	Sr.			18. Mother	r's Name <i>(First, M</i> ie Kenna:	iddle, Maider		
of Heal		19a. Informant's Name/Relationship (Ty, Beatrice Lewis (W: 20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ R	emoval from State	505] Place of Disponentery, crem	Plaza Co sition (Name of matory or other)	ourt, A	pt. 1A,	Aberde	or Town, State, Zip en MD 2 ocation - City or To	1001 own, State
permit. Pages 1 ar Depertment of Hea Importent: if Item: any injury or other		* 4 □Donation 5 □Other (Specify) 21. Signature of Euneral Service License	est Chesto P.A. n. MD 21							
death certificate be executed Water and water and and are as the burial-transit and tor use as the burial-transit and the partial and the par	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or wijury that inticated events resulting in death) Last	Due to (or as a conseq	uence of):	LENCY V	IRIIS				Onset and Death
that the death certific ed by the atfending pi detached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregna Other (specify,				23d. Date of delive Month	ery Day Year
8 69	by	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderlying cause	given in Part I.			use contribute to the	he cause of death?
	Completed						1 O Y	-	prior to co death?	psy findings available mpletion of cause of
Phys ral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 XVo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 Inpati	ER/Outpatien 28b. Time of Injury	28c. Ir	O#	28d. Desc		6 Other (Specification)	y) HOSPICE
itel or Attending rs efter death.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	eet, factory, office	ce		on (Street ar r Town, State	nd Number or Rura e)	al Route Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 X Certifying Phys 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the restigation, in m	e time, date and ny opinion, death	place, and due to h occurred at the t	the cause(s ime, date an) and manner as s d place, and due to	tated. o the cause(s)
To the P within 24 To the F complete	M	29b. Signature and title of certifier 30. Name and address of person who co	mpleted gauge of death //	22a) /T	I	ense number	125	29d. Da	ite signed (Month,	Day, Year)
Sta Regist		DR. TARIQ MAHMOOI		EY VALI	LEY RD.	TIMON	IUM, MD 2	21093	•	

APRIL 27, 2005 4:30 p.m.

DARLINGTON LEWIS

			For State Registrar	State of	Maryland		artment <i>rtificate</i>			and M		giene Reg. No.	005	1516	7
			Decedent's Name (First, Middle)	e, Last)							2. Date of De			3. Time of Dea	ath
н	Physicia	an	Alice		Μ						Month April	Day 25,	Year	7:56 AM	
	/Medic		4a. Facility Name (If not institution	Virginia		ran	4h. City. T	own. or	Location of	of Death	ADITI		unty of Death	7:36 AM	
	Examin	er			15017		,						. Mary		
-			Bayside Care 5. Social Security Number		7. Age (In yrs. Ia	ast birthday)			ton P		8. Date of Birt			S place (State or Fo	oreian
	Funeral			1 □ M 2 X F		Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da	y, Year)	Coui	ntry)	
	Director		215-22-7025 Usual Residence of Decedent		87						Mar. 1	, 191	8 Nort	h Carol	<u>ina</u>
	land ow		10a. State 10b. County		10c. City	, Town or La	cation						1	0d. Inside City Li	imits
	Mary	ō	Maryland St.	Mary's			C	t	Mi11s	-				1 Yes 2	® No
	the 286	ec	10e. Street and Number	rially 5			10f. Zip (MILLE	>		10g. Citizen	of What Cour	ntry?	
	with sor		20370 Flat Iron	Dood				20	1627						
	be filed within 72 hours after death with the Manyland Hygiene. Independent then "netural", or items 23e or 28e-f show of other then "netural", or item: 33e or 28e-f show event, the Manical Exacting a second, the Manical	Funeral Director	11. Marital Status		dent Ever in U.S	S. 13. V	Was Decede		0634	gin? (Spe	cify Yes or No		ed Sta		
	lter d	Ë	1 Never Married 2 Marr	Armed For	ces?		f Yes, specif	fy Cubar	n, Mexican	, Puerto	cify Yes or No Rican, etc.)		Black, White,		
21215-0036	irs af	by	3 Widowed 4 Divorced	If Yes, Give	е		1 ☐ Yes 2	No No	Specify:			Sp	ecity: Whi	te	
ğ	ture	ed	15. Deceden	t's Education		16a. Dece	dent's Usual	Occupa	ation			16b. Kind o	of Business/In	dustry	
57	in 72	Completed	(Specify only highes	st grade completed)		(Give	kind of work DO NOT use	done d	luring most	t of worki	ng				
2	with ene.	E	Elementary/Secondary (0-12)	College (1-	-40r 5+)		Нот	mema	kor			Orar	Home		
	filed Hygi other	Ö	17. Father's Name (First, Middle,	Last)				ine ine		ır's Name	(First, Middle,				
an	lid be lental ked c	o Be	Richard C.	Tom - G						For	ney Bet	+ Uodo	nath		
2	should be filed within nd Mental Hygiene. marked other then imatic event, tre M	은	19a. Informant's Name/Relations			19b. Mailir	na Address /	(Street a	nd Numbe		I Route Numbe			Code)	
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury or other traumatic e once.		John V. Moran /									i		nd 20634	<i>l</i> .
	1 an Heal em 2		20a. Method of Disposition	nuspand	20b. PI	ace of Dispo					ate at M.		maeyia ion - City or To		+
Baltimore,	ages to tro		1 Burial 2 ☐ Cremation		plate										
Ę.	t Pa trmer tant njury		'4 □Donation 5 □ Other (S		Eve	rgreen				-28	-2005	Great	Mills,	Marylan	nd
20	permit Depart Import any r		21. Signature of Emieral Service	the										me, P.A.	
	0.01 = 0.01		Edward N. Brins					_					m, MD	<u> 20650–02</u>	279
Ш			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	aused the death ach line.	. Do not ent	er the mode	of dying	g, such as	cardine o	r respiratory ar	res	_	Approximate Interval Between Onset and Dual	
15	Pnysician		Immediate Cause (Final disease or condition	2	Anu	lo.	hem	and	dial	m	fara	un	1	minul	al
	/Medical		resulting in death)	Due to (s a consequ	ience of):	1 1	1	1	17					
	Examiner		Sequentially list conditions	b	Cor	may	44/	TM	NX	711)e42	ase		WER	21
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):	1		1	-				1	
	be executed sician and burial-transit	am	that initiated events	с			V								
0,	e exe ian a urial-		resulting in death) Last	Due to (or as a consequ	ience of):									
8760,	at year	icai		d											
9	ng ph as t	Med	IF FEMALE:												
Вох	eath certif attending for use as	an/I	23b. Was decedent pregnant	23c. If yes, outo	ome of pregnar		Ectopic pre	gnancy				23d.	Date of delive	•	. 1
	death ed for	Physician/M	in the past 12 months? 1 Yes 2 8 No	4□Pregna 9□Unkno	ant at time of de	ath 5□	Other (spe	cify)					Month	Day Year	
<u>Р</u>	at the de by the a tached	h.	9 Unknown									1			
ď.	res tha igned be det	by F	Part II. Other significant condition	ons contributing to de	ath but not resu	ılting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco use o	contribute to the	ne cause of death	1?
big	w require been signature should b		*		1						1 🗆 \	res 2 🖪 N	o 3∏Prob	abły 4 🗆 Unkn	10WN
Record	aw re	Completed		Jems	ulis						24a. Was		4b. Were auto	psy findings avail	lable
m m	The lay te has age 2	mo									autop perfo 1 Tyes	rmed?	death?	2 No	9 01
Vital	icien: Th certificate rector, pag	Φ	25. Was case referred to medical				-		26. Place	of Death	(Check only o				
>	Attending Physicien: The Ir death. ector: After this certificate has ethe funeral director, page	To B	examiner? 1 🗌 Yes 2 🌇 No	Hospital: 1 ☐ Ir	npatient 2 2	ER/Outpatien	t 3□ DOA	Othe			ne 5 ☐ Resid		Other (Specifi	y)	
Division of	ding Phys h. After this funeral di		27. Manner of Death	28a. Date o	of Injury h, Day Year)	28b. Time of		c. Injury Work			28d. Describe h			,	
0	nding I tth. : After e funer	ertification:	1 Natural 5 Pendir 2 Accident investig	19	i, Day (ear)	Injury	М		r ∕es 2 🗆 i	No					
/!	or Attencater death Director: in by the	fic	3 ☐ Suicide 6 ☐ Could	ined 286. Place	of Injury - At ho		eet, factory,	office					umber or Rura	l Route Number,	
ā	afte Dir	ert	4 Homicide	Buildin	ig, etc. (Specify	7					City or Tox	m, State)			
	To the Hospitel or within 24 hours after To the Funerel Dia completely filled in	aic	29a. Certifier 1 Certifyir	ng Physician: To the	best of my know	wledge, death	occurred a	t the tim	e, date an	d place,	and due to the	cause(s) and	manner as s	ated.	-
	B HC	edicai	(Check only 2 Medical	Examiner: On the ba and mann		ion and/or in	vestigation, i	in my op	oinion, deat	th occurr	ed at the time,	date and pla	ce, and due to	the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c.	License	number			29d. Date si	gned (Month,	Day, Year)	
)	- ~		De son	art bo	Nose	-M (CL	DE	5419	7	4	-15-	-0.5	
0	184		30. Name and addry of person	who complete cause	e of death (Item	23a) (Type.	Print)			11		6	2		
			J. Patrick Ja	11		25		h R	oad.	Но11	vwood .	Marv1	and 204	536	
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	etrar's Signat	ture				ـــــــ	, wood 9	y 1	L. L. U	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Registr		VAPR 2	6 2005 🗶	The state of	B. A	cont.	,							

			For	i icasc	State of	of Maryla	nd / Depa	artment	t of H	lealth a		•		_		151	00
(Sec)	3		1 - State Registrar 4 -			Per FH R	cr Ce	rtificate	e of L	Death			Reg. No.	- 0 0	J	101	00
4.	Physicia	an	Decedent's Name (2. Date of De Month	Day		ar	3. Time of 0	Death PM
П	/Medic Examin		Hester 4a. Facility Name (If n	McCr not institution, give		ımbər)		4b. City, 1	Town, or	Location o	of Death	Apri1		200 County of D		3:02	
d	LAGITIII		Washingt	on Adv	entist	Hopi	ta1	Tako	ma	Park			Мо	ntgor	nery	7	
	Funeral		5. Social Security Nur	mber 6. S		7. Age (În yr	s. last birthday) Yrs.	If Under Months		If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da	ıy, Yəar)	9.	Birthplac Country	e (State or	Foreign
	Director		249-44-92 Usual Residence of D	218		81	113.					Sept2	4,19	2350	uth	Caro	olina
	nyland how		10a. State	10b. County Prince G	eorge's	10c. (City, Town or Lo	cation							10d	. Inside City	
	8e-fs	cto	Md.	Montgo	mery		attsvi									1X Yes	2 🗆 No
	death with the Maryland ms 23e or 28e-f show	Funeral Director	10e. Street and Numb					10f. Zip						zen of What	Country	?	
	ns 23	eral	2115 Ruat 11. Marital Status	tan Str	12. Was Dec	edent Ever in	U.S. 13.	207 Was Deced		ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	USA -	14. Race - A	merican	Indian,	
٥	after or Item		1 Never Married		Armed Fi 1 ☐ Yes If Yes, G	2 X No		lfYes,spec 1 □ Yes 2			, Puerto	Rican, etc.)		Black, W			
215-0036	thin 72 hours after death with the Marylar e. an "neturel", or Hems 23e or 28e-f show Medical Examener must be rediffed at	d by	3 🖾 Widowed 4		Year or 0	Dates:									31ac		
7	in 72 " net	Completed	(Specify	5. Decedent's En	de completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	during most	of work	ing	16b. Kır	nd of Busine	ss/Indus	stry	
212	d within glene. or than "I	mo	Elementary/Second	dary (0-12)	College ((1-4or 5+)	Labor	er					Pri	vate	Ind	ustr	У
B	be filed wintal Hygien of other that avent, The	Be C	17. Father's Name (F	irst, Middle, Last,						18. Mothe	r's Name	e (First, Middle					
<u>\</u>	should by nd Menta marked matic av	^o	Willie J			s Sr.						Jacks					
Maryland	d 2 sth arr		19a. Informant's Nam			,		•				al Route Numb Hyatt:					
	Head Head		Esther M 20a. Method of Dispo	sition	_	20b	Place of Dispo					Date		cation - City			
Ë	0 = 5		1 X Burial 2 □ `4 □ Donation 5			State	11iams				ori]	23,0	5 Be	nnet	tsv	ille	,sc
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Fund	eral rvice Lice	nsee) 23	2. Name and	d Addres	ss of Facility	у						
	2012	11	yro.	he A	you	ine	Ту	rone	J.	You	ng '	719 Ke	nne	ly St		W 20	
и			23a. Part 1 Inter the shock or heart Immediate Cause (Fi		one cause on	each line.	ath. Do not en	er the mode	e of dyin	g, such as	cardiac d	or respiratory a	rrest,		In	pproximate terval Betw nset and De	een
	Physician /Medical		disease or condition resulting in death)	iiiai	-		SCLING equence of):										
	Examiner				1/2	105%	TONSTA	5 /0	Some	TK	150	55					
	D to	iner	Sequentially list conditions, leading to immicause. Enter Underly Cause (Disease or in	nediate ying	Due to	(or as a cons	equence of): order equence of):		_	/1	ح. م	-					
	be executed sician and burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La	_		(or as a cons		CMX.	//	MIC					-		
760,	te be executed ysician and ne burial-transit	calE		- (d	(-,	-4										
89			15.555		u												
Box	death certifical e attending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m			tcome of preg birth 2 ☐ Fe		⊒Ectopic pre	egnancy				2	3d. Date of	delivery Da	V	ear
0	0 0 0	ysici	1 Yes 2 Unknown		4□Preg 9□Unkr	nant at time of nown	fdeath 5	Other (spe	ecify)					INIOHILI	De	ty re	iai
٩.	The law requires that the tee been signed by the sage 2 should be detache		Part II. Other signific	ant conditions	ontributing to c	death but not re	esulting in the u	nderlying ca	ause give	en in Part !.		23e. Did t	obacco u	se contribute	e to the o	ause of de	ath?
rds	quires n sign uld be	ed by										10	Yes 2⊌	3No 3□	Probabl	y 4∙∏Ur	known
Records,	aw require is been sig 2 should b	Completed										24a. Was		24b. Were	autopsy	findings av	vailable
		Com										autor perfo	rmed?	death	to compi i? 'es 2[etion of cau] No	JSE OI
/ita	tysician: Th	Be (25. Was case referre	d to medical	Linesiasi.				0.1		200	(Check only o	31.5				
of Vital	Phys this al dii	To.	1 ☐ Yes 2 ☐ N 27. Manner of Death	0	Hospital: 1 28a. Date		ER/Outpatier 28b. Time o	-	A Cthe	4 🗆 140		me 5 Resi			pecify)		
O	Jing After fune	tlon	1 XNatural 2 ☐ Accident	5 Pending	(Mor	nth, Day Year)	Injury	M	Work	γαι κ? Yes 2.∐1		EGG. Describe	1044 1111019	occurred			
Division	l or Attandi after death. Director: A in by the fu	Certification:	3 Suicide	6 Could not b	289. Plac	e of Injury - At ling, etc. (Spe	home, farm, sti	reet, factory,	, office		T	28f. Location (City or To	Street and	Number or	Rural R	oute Numb	er,
	ital or A rs after at Directed in by	Cert	- I tolliolog		Dulic						ļ	Ony Gr 701	wii, Olalej				
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only 2 one)	Certifying Plant □ Medical Exar	niner: On the b	pasis of exami	nowledge, deat nation and/or in	h occurred a vestigation,	at the tim	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner place, and c	as state	ed. e cause(s)	
	To the within 2 To the complet	Med	29b. Signature and til	tle of certifier +	and mar	nner stated.		29c.	License	e number			29d. Date	signed (Mo	onth, Daj	y, Year)	
)	6 4 8 4		New	100000	00111			u	un	576	514	/	4/	12/05	5		
R	(4)		30. Name and address	ss of person who	completed cau	se of death (It	em 23a) (Type,				/		1				
1			Dr.Don 1	M. Cole	eman,	7600	Carrol	1 Ave	2. [Takon	na F	ark,M	D 20	912			
	Sta Registr		31. Date filed (Month)	Day, Year) 200	20.1	Registrar's Sig	nature de										
			AFK	2 0 200	PLA	Me A	1										

within 24 hours a

To the Funerel I

completely filled

915

W

1

 α

7-0

J

3

MORRIS

Am 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) amem 31. Date filed (Month, Day, Year) State APR 2 0 2005 Registrar

29b. Signature and title of certifier

PRMC

100E 5 Carpou

29d. Date signed (Month, Day, Year)

SAUSBURY

Registrar's Signature 32.

			State of Marylar				•	•	÷.
		1 - For State Registrar	ĺ		rtificate of		, ,	leg. No 2 0 0	5 1517
Dhysia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Ye	3. Time of Death
Physic /Medi Exami	cal	Dorothy 4a. Facility Name (If not institution, give	Harvey street and number)	Mar	shall 4b. City, Town, o	or Location of Dea	April	23, 2005 4c. County of E	1:30 P
		Garrett County Me	morial Hospit	:a1		Oakland		Ga	rrett
Funeral		Social Security Number 6. Se	TM 2KTE		If Under 1 Year Months Days	If Under 24 Hrs Hours Min			Birthplace (State or Foreig Country)
Director		578-12-2819 Usual Residence of Decedent	89	Yrs.			Oct. 8,		Maryland
anylar show	-	10a. State 10b. County	10c. Ci	ty, Town or L	ocation				10d. Inside City Limit
88-1:	Funeral Director		rett			n Lake Pa			1 ☑ Yes 2 ☐ N
with t	Ē	10e. Street and Number			10f. Zip Code	01.550	1	0g. Citizen of What	
death ms 23	era	607 N Street, #18	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	21550 Hispanic Origin? (S	Specify Yes or No- rto Rican, etc.)	14. Race - A	Merican Indian,
after or than	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give				rto Rican, etc.)		/hite, etc.
ural',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:		1 ☐ Yes 2 🖾 No			Specify:	White
partition of e.j. Mary iding ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 ia marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic avant. I've Medicul Evanti act must be multiled at once.	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	orking	16b. Kind of Busine	ess/Industry
d with	шо	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		Secreta			Law Off	ice
e filed al Hyg otha vant,	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,		di to to
Ments Ments arked	10	Arthur Sc	ott H	arvey		Nora	L.	Sc	lomon
2 short and lam.		19a. Informant's Name/Relationship (T)		1				, City or Town, Stat	
C, n 1 and 1 and 1 ealth am 27 lher t		Joyce L. Steyer/ 20a. Method of Disposition			5 Steyer	Mine Roa		nd, Md. 2 20c. Location - City	
political de political de permit. Pages 1 ar Department of Heal Important: If itam any injury or other page.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or other pla	1			
injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicen	D11		n Cemeter 2. Name and Addre				r, Maryland
Depa Depa Impo any ir	1	> Ray O	Drein		Stewart I	,		2 S. Seco akland, M	
		23a. Part1. Enter the disease, of compleshock, or heart failure. List only o	ications that caused the deat ne cause on each line.						Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Respiratory		re				Years
Examiner			Due to (or as a consec	Manager 1					
DESCRIPTION OF THE PERSON OF T	Je.	Sequentially list conditions, if any, leading to immediate	b. End Stage C Due to (or as a conseq	quence of):					Years
cuted nd transit	Examiner	that initiated events	c						
icate be executed physician and sthe burial-transit	EX	resulting in death) Last	Due to (or as a conseq	quence of):					
tificate t g physical	dicai		d.						
BOX OF BOTH CONTROL OF THE CONTROL OF T	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of	delivery
death death e atte	icia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Feta		□Ectopic pregnancy □ Other (specify) _	<i>y</i>		Month	Day Year
at the d by the fetache	hys	9 Unknown	9□ Unknown						
gne gne		Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	inderlying cause giv	ren in Part I.			e to the cause of death? Probably 4 Unknow
he law require he has been si age 2 should b	Completed						24a. Was a autops		autopsy findings available to completion of cause of
hyaician: The law his certificate has t	Com						perform	ned? death	
cian:	Be	25. Was case referred to medical examiner?	Hospital:		211		ath (Check only on		
Phys.	2	1 ☐ Yes 2 ☒No 27. Manner of Death	1 ☑ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier		er: 4 ☐ Nursing I		ence 6 Other (S	Specify)
ding Ph th. After th funeral	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	20d. Describe no	W Injury occurred	
lor Attanding Physician: " after death. Diractor: After this certifica	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st fy)			28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by		29a. Certifier 1 to Certifying Phy	sician: To the best of my kno ner: On the basis of examina	owledge, deat	h occurred at the tir	me, date and place	e, and due to the ca	ause(s) and manner	as stated.
tha H hin 24 tha F	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens				
7 wit	-	29b. Signature and title of certifier					25	9d. Date signed (M	
		20 Name and address of any	I made	730)		6154		4/23/200)
		30. Name and address of person who co				o On1-1 -	nd Md ()1550	
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	MOLI A	cres Driv	e, Uakla	ua, Ma.	(1330	
Regist	rar	APR 2 7 2	UU5	B	Growth 5				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Christopher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Baltimore OSPITA 14 Funeral 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 218-48-9284 Days Min 1 X M 2 □ F Hours 58 Director September 28, 1946 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits tiom 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Maryland Allegany Lonaconing 1XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 West Main Street 21539 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify. White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Aden Miller Peryl French 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damien Miller-Son 22 West Main Street, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 25. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department of Important: if any injury or once Frostburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, Md. 21539 n t 23a. P. rt. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis 6 clau /Medical **Examiner** renal ailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed retrovical the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital
within 24 hours e
To the Funeral C TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number RES-000 April 22,2005 nd address of person who completed cause of death (Item 23a) (Type, Pnnt) STREET, BALTIMORE, MARYLAND AHHAD ; 600 NORTH WOLFE HOMAA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Month **Physician** April 20, 2005 <u>John F.X. McGovern SFO</u> 2:00 P.M/Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Charles County Nursing & Rehab. La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director <u>050-09-2838</u> 90 June 6,1914 Pennsylvania Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director r than "natural", or items 23a or 28a-f the Medical Examiner must be notifie Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Hallows USA 2012 All Court 20602 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 A Yes 2 □ No 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Detes: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Broker Insurance other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) end Mental <u>Philip P. McGovern</u> Florence M. Dowdle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) of Health f Item 27 Alice L. Bell/ daughter 2056 Chapelside Court, Waldorf, MD 20602 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If It any injury or c pnce. 1 □ Burial 2 □ Cremation 3 □ Removal from State **Jepartment** 4 ☐ Donation 5 ☐ Other (Specify) Laurelwood Cemetery 4/25/05Stroudsburg, PA 22. Name and Address of Facility Joseph J. Pula Funeral Home 21. Signature of Runeral Service Licensee M00945 23 North Ninth Street Stroudsburg, PA 18360 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Mar dimai PHALIGNANT DYSRHYTHONIA Examiner Due to (or as e consequence of): Examiner CAD ucans ettending physician end for use as the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of) 414ac CVA Box 68760, by Physician/Medical Due to (or as e consequence of) HTN Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 785 2 No 1 ☐ Yes 2 ☑ No ours efter death.

•ral Director: After this certifice filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2 ☑ No 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital or 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48119 APR 21, 2005 10 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) WALDONF. 12070 OLS LINE CTA SIL 100 MO RICHARD BRANSBORF 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State legue. APR 2 1 2005 Registrar

DHMH 16 Rev 6/95

			1_ State	partment of Health and Mertificate of Death		0000
			Registrar 1. Decedent's Name (First, Middle, Last)	ortinoate of Beath	2. Date of Deat	eg. No.: 3. Time of Death
	Physici		Betty Cochran McCann		Month April	Day Yeer 19 2005 8:25 A M
}	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	"IPITE	4c. County of Death
1			Laurelwood Nursing Home	Elkton		Cecil
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Foreign Country)
	Director		240 /2 1843 - /3		Jan.23,	
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	the Marylar 28a-f show notified at	ţo	Maryland Cecil North Eas	+		1X∏Yes 2 ☐ No
	r 28a	irec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Country?
	th wit	al D	205 River Manor Drive	21901	υ	nited States
	ams	ıner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 9	1 ☐ Yes 2 No Specify:		Specify: white
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show diseal Exantraer must be notified at	ed b		cedent's Usual Occupation		16b. Kind of Business/Industry
15	n na Nedak	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of worki . DO NOT use retired)	ing	,
212	d within giene. er than	mo:		Service		Board of Education
b	al Hy I othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, I	Maiden Sumame)
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Itam 27 Is marked other then "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examiner must be routified at	10	James A. Cochran	Thelma N		
Лaг	l 2 sh n and r ls m			illing Address (Street and Number or Rura		
	of Health of Health Itam 27 I			rammy Drive, Elkton		ad 21921 20c. Location - City or Town, State
Baltimore,	Pages nent of int: If It		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State North Ea	rematory or other place) st Methodist April	l 22,	and the same and the same
ij	그 등 원 등		' 4 □ Donation 5 □ Other (Specify) Cem	200 22. Name and Address of Facility		orth East, Maryland
Ba	Depar Depar Impor any ir		Mary H	CIT		eral Home h East,Maryland 21901
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.			
	Physician	61 1	Immediate Cause (Final disease or condition MEZASTATIC	UTWILL CA		Onset and Death
	/Medical		resulting in death) a	OT WHAT OF		
)	Examiner	L	Sequentially list conditions, b.			
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury			
	xecut and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai E				
9	tificating phy as the	ledic	<u> </u>			
Вох	death certific attending pl	N/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	B □Ectopic pregnancy		23d. Date of delivery
	b death	by Physician/Me		Other (specify)	**	Month Day Year
P.O.	that the de ed by the a detached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the	undorhing course even in Part t	23a Did toh	pacco use contribute to the cause of death?
S	S F 0	l by	Part is. Other significant containers contributing to death but not resulting in the	underlying cause given in Fait i.		es 2 No 3 Probably 4 Donknown
Ö	> 0 0	etec			24a. Was a	
Records,	e las has	Completed			autops	y prior to completion of cause of death?
[a	iclan: Th certificate ector, pag	e C	25. Was case referred to medical	26. Place of Death		2 🖃 No 1 🗆 Yes 2 🗆 No
>	S S	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpat	Othor		ence 6 Other (Specify)
0		n: T	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ow injury occurred
Sior	Attanding r death. sctor: After by the fune	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division of Vital	r Att ter de irect n by t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could n be determin 1 belief building, etc. (Specify)	street, factory, office	28f. Location (Sti City or Town	reet and Number or Rural Route Number, n, State)
	pital c		20g Contilion 1 Desire to Develop Table has a facility of the			
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the ca ed at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
	o the	Me	29b. Signature and title of centifier	29c. License number	25	9d. Date signed (Month, Day, Year)
	- > P U		I HILMAN	DS4073	1	9 APR OS
-	, <u>1</u>		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		N = / = 11
	4		Aven Storet us 817 CARCH	was COR NEWS	457LE	DE 19711
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		
	Regist	di	APR 2 0 2005 Seem 1 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death A Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 9:30pm **Physician** DRIL 2005 Charles Edward Moran /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VA MARY and
5. Social Security Number Health Call System
7. Age (In yrs. last birthday) 10121 Care If Under 1 Year / If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Dec. 28, 19 Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F 221-24-0738 68 1936 Delaware Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show event, the Madical Exercities count be notified at 1 ☐ Yes 2X No Directo Conowingo Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō United States 21918 775 Ragan Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 1 XNever Married 2 Married Specify: White 1 ☐ Yes 2X No 21215-0036 If Yes, Give Year or Dates:1956-62 Specify: þ 3 Widowed 4 Divorced and Mental Hygiene. is marked other then "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Disabled None 12 land; 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Viola Unknown Unknown Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frank Ragan/group home permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 is
eny injury or other treu 775 Ragan Road, Conowingo, MD 21918 administrator Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1

Burial 2 □ Cremation 3 □ Removal from State

1 □ Donation 5 □ Other (Specify) Apr. 22,2005 Rising Sun, MD Brookview Cemetery 22. Name and Address of FacilityR.T.Foard Funeral Home PA 21. Signature of Funeral Service License 111 South Queen ST., Rising Sun, MD 21911 uchang Parth. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shopk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LINKNOWN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other signif þ Records, 3 Probably 4 Inknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 2 No 1 Tyes Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 1 Impatient After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the hosping.
within 24 hours after death.
To the Funerel Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confitier

8

Registrar

lipinees

30. Name and address of person who

DHMH 17 Rev 1/2001

MARY and Health Care

Amended Item 8 per F.D. 04/20/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2005 2310 Donald Anthony Marcellino, Sr <u> April</u> 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 8. Date of Birth (Sear) 1949 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months **№** M 2□F Director 214-56-4074 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Directo MD Finksburg Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2004 Suffolk Road 21048 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 3 ☐ No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Chasney and Company 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Donald K. Marcellino Vivian M. Foos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna M. Marcellino/wife 2004 Suffolk Road Finksburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4/20/2005 1 🙀 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tailun Kespinatury Physician /Medical Due to (or as a consequence of): Examiner Atrial Honillahn Sequentially list conditions, if any, leading to animediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner R. Due to (or as a consequence of): with sleep opines by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to nedical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗘 🗸 🗸 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physiclen: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

item 27 is marked other then "naturel", or items 23e or 28e-f show other treumstic event, the Medical Examinar must be notified at

and Mental Hygiene.

Pages 1 and 2 should be I nent of Health and Mental I out: If item 27 Is marked o

within 24 hours after death.

To the Funere! Director: After thi
completely filled in by the funeral To the Hospitel within 24 hours a To the Funerel I Medical

WIL 20

29b. Signature and

title of certifier

29c. License number D-0054218

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAIMAN

KAHERIA

349 Malcolm dure Westminster MD 21159

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

32. Regular's Signature

APR 1 8 2005

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 201 April 26, 2005 **Physician** 9:15 PM M Anna P. Mikula /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Glade Valley Nursing & Rehabilitation Center Walkersville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Mar. 9. Birthplace (State or Foreign Country)
New Jersey 6 Sex **Funeral** Days 1915 Hours 90 1 □ M 2 □ F 181-38-0181 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits
1 ☐ Yes 2 ☐ No 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at Monrovia Maryland Frederick **Funeral Director** 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code with 1 21770 11735 Weller Hill Drive death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 tours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Item any Injury or other traumatic event, It a Medical Establish Once. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes X No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Matey George Pavelka 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11735 Weller Hill Dr., Monrovia, MD 21770 Mrs. Anna Psioda, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithfield E.E. Cemetery 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Apr. 30, 2005 Pittsburgh, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21. Signature of Funeral Service Licensee ruchan M00255 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Immediate Cause (Final Heart Physician 2 week disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner pertension eens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ogas a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): nding physician a use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementra 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: r 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time ot 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Japitar - A hours after dea. - - real Director: After the fire. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of contin 29c. License number D 43091 April 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saeed A. Zaidi, M.D., 801 Toll House Ave., # E-1, Frederick, MD 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #7, #8, #18, Per Funeral Home Certificate of Death 04/20/05, Reg. NdVCHD, C.H. Amended Item 2. Date of Death Decedent's Name (First, Middle, Last) 18 10:26 AM **Physician** 00 05 sea. /Medical 4a. Facility Name (If not institution, give street and number) do. City, Town, or Location of Death 4c. County of Death Examiner serera Worceste Atlantic 8. Date of Birth11/10/30. Birthplace (State or Foreign (Month, Day, Year)
11/10/28 North Carolina If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1₩ 2□F Yrs 239 40 1770 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ed other than "natural", or itema 23a or 28a-f show event, the Medical Exandramer must be notified at Yes 2 No Maryland Worcester Berlin Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 9715 Healthway Drive 21811 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 21215-003 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Cash Elementary/Secondary (0-12) College (1-4or 5+) Register Supervisor Я 2002 pelij marked other 18. Mother's Name (First, Middle, Maiden Sumame) 18/2/2 land 17 Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Sadie Wisenhunt John E. McCreary Cinda Whifnant ary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 6839 Whiton Crossing Road Berlin, MD 21811 Phillip David McCary 1930 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State ō Cape Henlopen Crem 4/19/05 Frankford, DE 101 * 4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral 108 William St. 22. Name and Address of Facility The Burbage Funeral Home Berlin, MD dilease in complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause in each line. Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease shock, or hear failure. Immediate Cause (Final disease or condition oiration Physician PARUMONI /Medical resulting in death) Due to (or as a consequence of): Examiner TONSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 | Fetal death Day Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0059945 COL, FAN, MB MISTINE M. ERIF who completed cause of death (Item 23a) (Type, Print) FENUICK ISLAND HIGHWALI State Registrar

				for A	Plea Amend I	-	-							_		Legible.	
		Physicia /Medic		Registrar 1. Decedent's Nam IRMA NELS	ne (First, Middle			,		Cen	iricate d	or Dean	n	2. Date of De Month	ath Da	.000	3. Time of Death
)	Examin		4a. Facility Name (16 NES	give st	reet and nu	imber)	4NE		4b. City Tow	m, or Location	n of Death	7		County of Dea	
		Funeral Director		5. Social Security N 219–12–9529	9	6. Sex 1 □	м 2Х∫ F		n yrs. last bii 80	rthday)_ Yrs.	If Under 1 You Months Da	ear If Undo ays Hours	er 24 Hrs Min.	8. Date of Bir (Month, Da 2–16–192	th ay, Year) 24	9. Bir C Mary	thplace (State or Foreign ountry) Land
	with the Maryland	or 28a-f show e notified at	tor	Usual Residence of 10a. State	10b. County			10	Oc. City, Tow	m or Loc	ation						10d. Inside City Limits 1 X Yes 2 □ No
	th with the	23a or 28a	Funeral Director	10e. Street and Nu. 740 Poplar		Apt 1	LO H				10f. Zip Cor 21216				10g. Cit	izen of What C	ountry?
G	USO urs after deal	popartiment of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant. Its Medical Examinat must be notified at once.	þ	11. Marital Status 1 ☑ Never Marr 3 ☐ Widowed		ried	2. Was Dec Armed F 1 ☐ Yes If Yes, G Year or I	orces? 2 X No ive	er in U.S.		as Decedent Yes, specify (ecify Yes or No Rican, etc.)	D-	14. Race - Am Black, Whi Specify: B1	
	Maryland 21213-0030 d2 should be filed within 72 hours aft	iene. than "natur he Medical	Completed	(Special Special Speci	15. Deceden icify only highe ondary (0-12)		completed,) (1-4or 5+)	16a	(Give k life. D	int's Usual Oci ind of work do O NOT use re ood Serv	one during me etired)	ost of worki	ng		ind of Business	
	Viana z	Mental Hygi arked othar	To Be Co	17. Father's Name Joseph Ne		Last)						18. Mot		e (First, Middle e Nelson		Surname)	
	s, Mar,	ealth and m 27 is ma		19a. Informant's N	Smith/ Da					271	5 Baker	Street	Balti	more, MD	212		
:	Galtimore,	tment of H rtant: If ita		° 4 □ Donation	Cremation 5 Other (S	pecify)		State	Comete King Me	moria		place)	02-07	-05		allstown	
1	מ מ	Depa Impo any in		21. Signature of Fi	mela	, O	mas	caused the	e death Do	Wy	lie Fun		ne 638			eet Balto	Approximate
•	1	nysician /Medical xaminer		z3a. Part1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	(Final	only one	1	NEU (or as a c	IMON consequence	1 A of):	**************************************	FECT		1		EXAMINER .	Interval Between Onset and Death
	50, be executed	ician and burial-transit	Examiner	Sequentially list configures, reading to incause. Enter Under Cause (Disease on that initiated event resulting in death)	inmediate lerlying r injury ts	b. с.	Due to	(SF ac a c E SP (or as a c	IRATI onsequence	of): of):	FAILL	URE_	CERTIFIC	NON APPROV	ED BY ME	OICAL EXAMINER	unit nows
1			fedical			d.	0	D C	EREK	BRO	VASUV	LAR	OKSE	NE			HAKADOS
A.	ords, P.O. Box 687	ed by the attending detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? ☑No	23		birth 2 [nant at tim	pregnancy Fetal death ne of death		Ectopic pregn Other (specif					23d. Date of de Month	livery Day Year
RM	rds, F	n signed t	d by P	Part II. Other signi			tributing to		not resulting i			e given in Par	nt I.		tobacco i Yes 2		o the cause of death? robably 4 Munknown
117	Heco.	has t	omplete	PENAI	IIA LFAIL	uRE	•							24a. Was auto perfo 1 ☐ Yes		prior to	utopsy findings available completion of cause of
\$			Be C	25. Was case refe examiner?								26. Pla	ice of Death	(Check only		10.16	2 140
2	Of V	this ce	2	1 X es 2)	fino	Ho		Inpatient			3□ DOA					6 □Other (Spe	ecify)
THE	On C	h. After th funeral	inol.	27. Manner of Dea 1- Whateral	5 🗌 Pendii			of Injury nth, Day Y		Time of Injury		Injury at Work? 1 □ Yes 2]		28d. Describe Subject		*	
<	DIVISION Of VITA	ours after death	Certification;	2 Xaccident 3 Suicide 4 Homicide	6 ☐ Could		28e. Plac build	ding, etc. (- At home, fa 'Specify)	arm, stre	et, factory, of			28f. Location (City or To	Street an	d Number or R	ural Route Number,
	Hospita	within 24 hours and the Funaral I completely filled	edical C	29a. Certifier (Check only one)			ician: To the		my knowledg camination ar				and place,	and due to the	cause(s	and manner a	
	Tothe	within To th comp	Me	29b. Signature and	d title of certifie	iz	NED	Min	RES	1/Pers		2/862			_	te signed (Mon	th, Day, Year)
		1		Tu Traine and add	TIONAL IST. DATE:												-, -000

り State Registrar

31. Date filed (Month, Day, Year)

100 CATON AVE BALTIMORE MARYLAND
32. Registrar's Signature

			1 - For State Registrar		State of			l / Depa		t of H	lealth	and M	lental Hy			F.	1 200	1 .4 0
	Division		1. Decedent's Name (First, A	fiddle, Li	ast)								2. Date of De	ath		J -	3. Time o	of Death
	Physic /Medi Examir	cal	Edith Lou 4a. Facility Name (If not instit	ise ution, gi	Oechs	ler			4b. City,	Town, or	Location	of Death	April	17,	200 County of		8:19) a ^M
			Millennium								vate			A	nne	Arı	nde1	
	Funeral Director	2.1	5. Social Security Number 064-16-5114 Usual Residence of Deceder		Sex 1□M 2∏XF		'In yrs. Ia 3	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 7/7/]	th ly, Year)			lace (State try) NY	
	land ow		10a. State 10b. Co			1	Oc. City,	Town or Lo	cation							11	Od. Inside C	City Limits
	a-fst	ctor	MD Ann	e Aı	unde1					Lo	thia	an					1 XYes	5 2 □ No
	or 28	Funeral Director	10e. Street and Number						10f. Zip					10g. Citiz	en of Wha	t Coun	try?	
	s 23a	ral	213 5th St	ceet							711					5A		
	ter de item	-une	11. Marital Status 1 ☐ Never Married 2 ☐	Married	12. Was Dec Armed Fo 1 ☐ Yes	orces?	er in U.S.	. 13. V	Vas Deced Yes, spec	fent of Hi orfy Cuba	spanic Or n, Mexica	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race Black, \			
036	ursat al', or	by	3 ☐ Widowed 4 X Divo		If Yes, Gi Year or D	ive		1	☐ Yes 2	2 X No	Specify	:			Specify:	Wh	ite	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show Jical Evant, per mest be to diffed at	Completed	15. Dece (Specify only h	dent's E	ducation			16a. Deced	lent's Usua kind of wor	I Occupa	ation	st of worki	ina	16b. Kin	d of Busin	ess/ind	ustry	
121	within ene. than "	mpl	Elementary/Secondary (0-		College (life. L	OO NOT us	e retired,)			.	_	~		
	filled Hygi ther ant, I	Co	12 17. Father's Name (First, Mig	dle. Lasi	')				Se	cre	tary		e (First, Middle,			Go	vern	ment
<u>a</u>	should be nd Mental marked o matic ave	To Be	William St	oth	ers								e Loui			sic	C	
Maryland	and Manar	-	19a. Informant's Name/Relat					19b. Mailin	g Address	(Street a			Il Route Numbe					
	and 2 ealth m 27 i		Scott Oechs	sler	/Son						eet,		thian,	MD	2071	1		
Ore	ges 1 t of H If ited or oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremat	ion 3[Removal from		20b. Pla cen	ce of Dispos netery, crem	sition (Nam natory or o	ne of ther place	· 1		Date		ation - City			
Baltimore,	it. Pa idmen idmen idury njury		`4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Sen	- 1			Che	sape			n . !		/2005					
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a once.		16.6	10	W	١		P		x 43	30,	Dunk	ymond.	D	d F. 2075		P.A	١.
THE REAL PROPERTY.	Pnysician /Medical Examiner	_	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	e, or com List only	a. Due to	or as a c	200 conseque	ngy ince of): Very	Y	Em	bol	ism bos	7 .	rest,			Approxima Interval Bei Onset and	tween
8760,	Attanding Phyaician: The law requires that the death certificate be executed refath. cleath. ector: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit	dical Examiner	il airy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	C.	(or as a c		,										
P.O. Box 6	the death certific by the attending p ached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			oirth 2 [nant at tim	Fetal d	eath 3 🗌	Ectopic pre Other (spe					23	d. Date of Month			Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant con Dement		contributing to d	eath but r	not resulti	ing in the un	derlying ca	use give	n in Part I			obacco use			cause of c	-
Records,	alcian: The law re certificate has be irector, page 2 sho	Completed	Atherosc Periphen		Vasc						isea	Se,		med?	prior deatl	to com	sy findings pletion of c	available ause of
ta	lan: rtifica stor, p	BeC	25. Was case re erred to med		VCESL	DLF	113	DI	sea		26. Place	of Death	1 ☐ Yes Check only o	2 ☑No ne)	1 🗆 '	res 2	2 ∐ No	
<u>></u>	hyaic his ce I direc	To E	examiner? 1 Yes 2 No					R/Outpatient	3 🗆 DO				ne 5□Resid		Other (S	Specify)		*
ono	iding Phyaician: The Ih. In.: After this certificate ha funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pe 2 ☐ Accident inv	nding estigatio	28a. Date (Mon	of Injury th, Day Y	ear) 2	8b. Time of Injury	28 M	Bc. Injury Work	at ? es 2 □	2	8d. Describe h					
Division of Vital	afte Dir	Certification:	3 ☐ Suicide 6 ☐ Co	uld not b ermined	e 28e. Place	of Injury ing, etc. (- At hom Specify)	e, farm, stre					28f. Location (S City or Tow	Street and in, State)	Vumber o	' Rural	Route Num	ber,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai (29a. Certifier 1 Certi (Check only 2 Medi	fying Ph cal Exar	ysician: To the niner: On the b and man	best of n asis of ex ner stated	aminatio	edge, death n and/or inv	occurred a estigation,	t the time	e, date an inion, dea	d place, a th occurre	and due to the dead at the time, o	ause(s) ai date and p	nd manne lace, and	as sta	ted. he cause(s	:)
	To the To the comp	M	29b. Signature and title of cer	tifier	c (24:	13.5	1.0	1	License				29d. Date :	-		,	
		13			. 0			14.					3					
	6		30. Name and address of per-	DRO	completed caus	be of death	h (Item 2 クル	3a) (Type, F	Print) C	YA	N .	C.D.	SUR	AW,	20	20	751	
	Sta Registr	te	31. Date filed (Month, Day Y	R 1	9 2005)	egistr	Signatur	K	Spe	R. P								

			1 _ State		artment of Health a	, ,	2005	15-100	
	Physic	ian	Registrar 1. Decedent's Name (First, Middle, Last) Joseph	Wesley Powell	incate of Death	2. Date of Dea	Reg. No. U () () ath Day Year 11 18, 2005	3. Time of Death 9:25 A M	
	/Medi Examir		4a. Fecility Name (If not institution, give street and num Devlin Manor Num	nber) sing Home	4b. City, Town, or Location o		4c. County of Death		
	Funeral Director		5. Social Security Number 213-22-4451 6. Sex 1 M/2 □ F	7. Age <i>(In yrs. last birthd</i> ay) 77 Yrs.	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day June 05	9. Birth (, Year) Cou	place (State or Foreign ntry) Maryland	
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			1	10d. Inside City Limits	
	r 28e-f s	Director	Maryland Allegany 10e. Street and Number		Lonacor		10g. Citizen of What Cour	1 X Yes 2 □ No ntry?	
	leath witi	eral D	26 Island Street 11. Marital Status 12. Was Dece	dent Ever in U.S. 13. V	21539 Vas Decedent of Hispanic Orig		USA 14. Race - Americ		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "netural", or Items 23e or 28e-f show says injury or other treumatic event, Ite Mudical Examinar must be rotified at ance.	by Funeral	1 Never Married 2 Married 1 Yes 1 1 Yes Given Sal Widowed 4 Divorced 1 Never Day 1 Year or Day	rces? 2 □ No	Yes, specify Cuban, Mexican.	Puerto Rican, etc.)	Black, White,		
21215-0036	within 72 h ane. than "netu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-8)	(Give	ent's Usual Occupation kind of work done during most DO NOT use retired) Truck Driv		16b. Kind of Business/In	•	
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than any rigury or other treumatic event, Item 2006.	To Be Co	17. Father's Name (First, Middle, Last) Joseph Po	well	18. Mother	r's Name (First, Middle, Mar	Maiden Sumame) y Jane Spiker		
, Maryland	alth and Malth and M		19a. Informant's Name/Relationship (Type, Print) Sharon Brennan/Daughter	19b. Mailin	g Address (Street and Number 12700 Walsh R		r, City or Town, State, Zipge, Maryland 2154		
Baltimore,	Pages 1 and neut of Helent of Helent ury or other		20a. Method of Disposition 1		sition (Name of latory or other place) Veterans Cemetery	April 22, 2005	20c. Location - City or To Flintstone, N		
Balt	permit. Departr Importe any inji		21. Signature of Funeral Service Ligensee		Name and Address of Facility		Main St., Lonacon	ing, Md. 21539	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that call shock, or heart failure. List only one cause on earlier cause (Final disease or condition resulting in death) Due to (or shock)	used the death. Do not enter ch line. Y JN BY or as a consequence of):	or the mode of dying, such as on the year Different		est,	Approximate Interval Between Onset and Death	
68760,	De executed cian and ourial-transit	ai Examiner	Cause (Disease or injury that initiated events c.	or as a consequence of):					
P.O. Box 687	ath certific ittending p or use as	Physician/Medicai	in the past 12 months?	nt at time of death 5 🗌	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year	
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to de	ath but not resulting in the un History	derlying cause given in Part I.	0	pacco use contribute to the		
Vital Records,		Completed	Infarct "			24a. Was ar autops perform 1 \(\text{Yes} \) 2	y prior to con	osy findings available inpletion of cause of 2 No	
f Vita	ysicien: is certifical director, p	To Be	25. Was case referred to medical examiner? 1 \subseteq Yes 2 \subseteq No Hospital: 1 \subseteq In	patient 2 ☐ ER/Outpatient	Other	of Death (Check only one	e) nnce 6 Other (Specify		
1 Inpatient 2 ER/Outpatient 3 DOA surviving Home 5 Residence 6 Other (27. Manger of Death Total Auril 5 Pending investigation 28a. Date of Injury Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No									
Division	Hospitel or Attending Physicien: 44 hours after death. Funeral Director: After this certificitied in by the funeral director.	Certification;	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home, farm, stre g, etc. (Specify)	et, factory, office	28f. Location (Str City or Town	reet and Number or Rural s, State)	Route Number,	
	To the Hospitel or Attu within 24 hours after de To the Funeral Directo completely filled in by th	ledical	29a. Certifier (Check only one) Certifying Physician: To the identifier on the base and manner.	sis of examination and/or invi	estigation, in my opinion, death	place, and due to the ca occurred at the time, da	tuse(s) and manner as sta ate and place, and due to	ated. the cause(s)	
)	To To Cont	2	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Month, E	Day, Year)	
_	131K			of death (Item 23a) (Type, P	Frostbung,	Maryland	21532		
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 2 2 2005 32. Re	gistrar's Signature	Goods .				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year GEORGE WARREN PERKINS, SR. **Physician** 8:02 P M 17, APRIL 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 84 049-14-1678 Yrs. Director 10/15/1920 NEW YORK Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD CARROLL FINKSBURG 1 Yes 2 No Director 10e. Street and Numbe 10f. Zio Code 10g. Citizen of What Country? 1955 VALHALLA DR. 21048 USA Completed by Funeral fited withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates:₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) TOOL MAKER MANUFACTURING 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be finance of and Mental H GORDON PERKINS Pages 1 and 2 should by ment of Health and Menta lant: If Item 27 is marked GOLDIE MERRITHEW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE W. PERKINS, JR.-SON 1955 VALHALLA DR., FINKSBURG, MD. 21048 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ALL COUNTY CREMATION 4/18/05 SYKESVILLE, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Authoroschwotic UNK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did topacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an VASC LLUZBY autopsy performed; 2 1 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be completely filled in by the funeral director 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mannef of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies MJ 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) 125 AIRPORT DR., WESTMINSTER, RUZBARSKY, MD/ PHILIP J. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 9 2005 Registrar

DONALD MARSHALL PATTORSON

			Amended Item 12 per F.D. (Please Type or Print)4/18/2 in Black	005 Carroll County, Indelible Ink. Ensure Al	wj1 I Copies A	re Legible.	
			State of Mary State Registrer		epartment of Health and M Certificate of Death		ene . No 2 0 0 5	15100
	Physici	an	Decedent's Name (First, Middle, Last) DONALD MARSHALL PATTERS			2. Date of Death	4, 2005 ear	3. Time of Death 5:18 PM
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) CARROLL HOSPITAL CENTER	7014	4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death	J. 10 11m
	Funeral Director		219–32–4534 XX ^{M 2□F}	n yrs. last birthe	Months Days Hours Min	8. Date of Birth (Month, Day, Y)	ear) Cour	lace (State or Foreign stry) YLAND
	Maryland -f show	tor		Oc. City, Town OESTMINS			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28a st be notif	al Director	10e. Street and Number 1401 HIGH STREET		10f. Zip Code 21158	109	. Citizen of What Coun NITED STAT	try? ES
920	be filed within 72 hours after death with the Maryland the Hygiene. A let Hygiene do ther than "natural; or items 23a or 28a-f show svent, I're Madical Examiner mant be natified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 No Yes 2 No If Yes, Give Year or Dates:	1956	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto Yes 2	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.
Maryland 21215-0036	within 72 ho ene. than "natur te Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(6	Decedent's Usual Occupation Give kind of work done during most of work life. DO NDT use retired) MACHINE SHOP ADJUS	ng	b. Kind of Business/Ind	dustry
land 2	be filed ital Hygi id other svent, I	To Be Co	17. Father's Name (First, Middle, Last) MARSHALL COLE PATTERSON			(First, Middle, Ma. ET ELIZAE	iden Sumame) BETH RAVER	
	tra tra		19a. Informant's Name/Relationship (Type, Print) PAULINE M. PATTERSON/WIFE	140	Mailing Address (Street and Number or Rura 01 HIGH STREET, WEST	MINSTER,	MD 21158	
altimore,	Pages ment or ant: if		1 Burial 2 □ Cremation 3 □ Removal from State Output Donation 5 □ Other (Specify)	cemetery.	crematory or other place) BRANCH CEMETERY 04/		c. Location - City or To WESTMINSTE	wn, State IR, MARYLAND
Ba	permit. Departimport. Import. any inj		21. Signature of Funeral Service Licensee	\Rightarrow	22. Name and Address of Facility MYERS-DURBORAW FUNE 91 WILLIS STREET,	RAL HOME, WESTMINS	P.A. TER, MD 21	157
	Physician /Medical		Immediate Cause (Final disease or complications that caused the shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition)	STATI	C BLADDER CA	r respiratory arrest		Approximate Interval Between Onset and Death
	Examiner popularity	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	onsequence of)):			
68760,	ficate be exec physician and the burial-tr	EX	resulting in death) Last Due to (or as a co	onsequence of)):			
.O. Box 6	eath certi attending for use a	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 ronths? 1 Yes 2 No 9 Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
<u>α</u>	w requires that the dibean signed by the should be detached	þ	Part II. Other significant conditions contributing to death but n	ot resulting in t	he underlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
al Records,		Completed				24a. Was an autopsy performed	prior to con death?	osy findings available inpletion of cause of 2 No
Vital	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient	2 🗆 ER/Outp	26. Place of Death eatient 3 DOA Cther: 4 Nursing Hor		e 6 □Other (Specify	•)
n of	Attending Physician: r death. ector: After this certific. by the funeral director,	-	27. Manper of Death 1 Natural 5 ☐ Pending (Month, Day Ye	28b. Tin	ne of 28c. Injury at 28c. Work?	28d. Describe how		
Division of	or Dir	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5)	- At home, farm Specify)	M 1 Yes 2 No	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of many one and manner stated	amination and/	death occurred at the time, date and place, a or investigation, in my opinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
	Yoth within To th comp	Me	29b. Signature and title of certifier	~ TV	29c. License number		Date signed (Month, L	

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

STONER AUGUL WESTMINSTER MALLING

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2005 APRIL 15, **Physician** Year RALPH HERBERT PEIFFER 12:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5393 KLEE MILL ROAD SYKESVILLE CARROLL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XX M 2 F Months Days Hours Min Yrs. 199-36-4533 Director 56 PENNSYLVANIA 20,1948 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show The Medical Examiner must be notified at MARYLAND 1 ☐ Yes 2 ☐ No CARROLL Director SYKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5393 KLEE MILL ROAD 21784 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√2] Yes 2 □ No 1/4 Yes, Give Year or Dates: VIETNAM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after di il Hygiene. other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: if item 27 is marked other thi any lojury or other treumatic event, ITE ODGS. 12 GROUND CREW CHIEF **AIRLINES** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HERBERT PEIFFER MARTHA KATHLEEN PAHLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANDY ZARRIELLO PEIFFER/WIFE 5393 KLEE MILL RD, SYKESVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) CARROLL CREMATION 04/19/2005 HAMPSTEAD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the total shock, or heart failure. List only one cause on each line. WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Amyotrophic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit pue Due to (or as a consequence of): Records, P.O. Box 68760, nding physician Physician/Medical use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten ned by the atter detached for u 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 2 No 1 Yes 1 Yes Division of Vital Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide × 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier MI それん 1) 33320 30. Name and address of person who completed callise of death (Item 23a) (Type, Print) MICHAEL F. GLOTH, M.D. 210 BUSINESS CENTER DRIVE, REISTERSTOWN, MD 21146 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 8 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth April 27, Dey 2005 Year Jean Ann Poughkeepsie 12:00 PM 4b. City, Town, or Locetion of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. lest birthday) 1□M 2√2F Yrs. 216-14-3932 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥☐Yes 2☐No Harford Aberdeen Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 643 Brenda Lane 21001 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: 3√2 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nurse nursing 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winkler William L. McMaster Naomi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 643 Brenda Lane, Aberdeen, MD 21001 Bruce M. Poughkeepsie (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4/28/05 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Co., Inc 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Pert1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) CONGESTIVE Due to (or es a consequence of): HYPERTENSION Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HOART DISBASE 1 ☐ Yes 22 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CARCINOMA LUNG 24a. Wes en autopsy performed? TL Yes 2001to 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

28c. Injury et Work?

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

or Attending Physicien:

s efter deam.
el Director: After the

within 24 hours efter des To the Funeral Director completely filled in by th

JEAN POUGhKEEPSIE

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

Maryland 21215-0020

Depertment of Health and Mental Important: If Item 27 is marked of

Physician

/Medical

Examiner

Physician/Medical Examine <u>م</u> Be Completed Medical Certification: To 27. Menner of Death

13CHEMIC

Other: 4 Narsing Home 5 - Residence 6 - Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Learnifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Yeer) 208096 APRIL 27, 2005

Andre Norosloroli Ko 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ANDRON NOWAROWSKI

MD 125 N. MAIN ST. BELAIR, MD2101X

State Registrar 31. Dete filed (Month, Day, Year)

1 ► Natural 2 □ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

MAY 0 2 2005

5 ☐ Pending investigation

6 Could not be determined



DHMH 16 Rev 6/95

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vaar **Physician** APRIL 2005 17, 6:01 A MILDRED C. RITTER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES LAUREL REGIONAL HOSPITAL LAUREL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 201 Months Director 85 JAN. 29, 1920 VIRĞINIA 227 14 4974 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f ehow rai', or items 23s or 28s-f ehov Exculter a ust be notified at XX Yes 2 No Directo MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2918 FAIRLAND ROAD UNITED STATES 20904 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hygiene. other than "natural", or iten 1 Never Married 2 Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify Specify: BLACK ğ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Madical Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wn Department of Heelth and Mental Hygient important: if Item 27 ie marked other that any injury or other traumatic according to the page. INTERNAL REVENUE SVC. ADMINISTRATIVE SUPERVISOR 1 YR. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be DELLA COLES ROBERT W. COLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SILVER SPRING, MD 20904 <u>IZZETTA CALLAHAN / </u>SISTER 2918 FAIRLAND RD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 04/23/2005 BRENTWOOD, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. ares 4308 SUITLAND ROAD SULLLAND, MD 20746 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate & ause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown CARDIAC ARRYTHMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe The certificate 1 ☐ Yes 2 ☐ No 1□ Yes XXNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes XX No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospitai 29a Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Berzing. D0056986 Iralaic-, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 105 GREENBELT, MD 21075 7500 HANOVER PARKWAY CHALAK BERZINGI, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State APR 2 1 2005

DHMH 17 Rev 1/200

Registrar

P.O.

			For State	State of Maryla	ınd / Depa	irtment of	f Health and N	-	_	15	15106
			Registrar		Cer	tificate c	of Death		Reg. No.	1 0	13100
	Physicia	an	Decedent's Name (First, Middle, Las					2. Date of De Month	Day Y	ear	Time of Death
	/Medic		Julia Ann Ruby						14, 2005		L837 M
	Examin	er	4a. Fecility Name (If not institution, give				n, or Location of Death		4c. County of		
			Carroll Hospital				tminster	1.5		roll	·
	Funeral		5. Social Security Number 6. Se	ox 7. Age (In yr □ M 2⊠F 69	s. last birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Bir (Month, Da Jul 18	th ly, Year)		(State or Foreign
	Director		213-36-0361 Usual Residence of Decedent	09	113.			Jul 10	, 1935	Maryla	and
	land W		10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Ir	nside City Limits
	Many feho	ō	Maryland Carro	11			Hampstead			1	□Yes 2X No
23	28a	rec	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of Wh	at Country?	
9	atter death with the Maryland or items 23s or 28s-f show I'd or marks or calified at	Funeral Director	2637 Hampstead M	Mexico Road			21074		US	A	
2	ms 2	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puert	pecify Yes or No	- 14. Race -	American In White, etc.	ndian,
6	after or ite	F	1 ☐ Never Married 2 🙀 Marned	1 ☐ Yes 2 ☑ No		Yes 21		5 1 110d11, 010.7	Specify:		ite
93	72 hours after death with the Marylar "naturel", or items 23e or 28a-f ehow raical Erat from mark to modified at	d by	3 Widowed 4 Divorced	Year or Dates:							
5 5	72 h natu	ete	15. Decedent's Ed (Specify only highest gra-	lucation de completed)	16a. Deced	lent's Usual Ockind of work do	cupation one during most of wor tired)	king	16b. Kind of Busin	ness/Industr	у
$\leq \frac{7}{2}$	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Jurses A			Nurs:	ing Ho	me
4 N	Hed y	ပိ	17. Father's Name (First, Middle, Last)			TOLDED 1		ne (First, Middle	, Maiden Sumame)		
anc	ntal led o	Be	George Vernon S					ces Ster			
ZZ	hould Me mark matic	ရ	19a, Informant's Name/Relationship (7		19b. Mailin	g Address (Str	eet and Number or Ru	ral Route Numb	er, City or Town, St.	ate, Zip Cod	(e)
Maryland 21215-0036	d 2 s ith an 27 is trau		Claude L. Ruby, h	* * * * * * * * * * * * * * * * * * * *		•	ead Mexico				
\mathcal{L} \mathcal{L} \mathcal{L} Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Heath and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-f ehov or other traumatic event, the Medical East it at market be rediffed at		20a. Method of Disposition	1	. Place of Dispo-	sition (Name of	place	Date	20c. Location - Ci	ty or Town,	State
2 5	ages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		t. John'			3/2005	Westmin	nster,	MD
	artmoortar		21. Signature of Fineral Service Licen		3 22	. Name and Ad	Idress of Facility	Eline Fu	neral Hor		
, m	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "ns eny injury or other traumatic event, the Media Once.		XHIMA	Woll	u	934 Soi	uth Main St				
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de	eath. Do not ente	er the mode of	dying, such as cardiac	or respiratory a	rrest,	App	roximate rval Between
	Physician		Immediate Cause (Final disease or condition	_	20515		drome			Ons	set and Death
	/Medical		resulting in death)	Due to (or as a cons	-	1.10	× 0/ C				ov certs
	Examiner		Sequentially list conditions	b							
	p H	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):						
	te be executed ysicien and ie burial-transit	cam	that initiated events resulting in death) Last	cDue to (or as a cons	equence of):						
760,	be execuicien and burial-trai	cal E		Due to (or as a coris	aquanica oi).						
87	physic the	dic		d	_						
Вох 68	ding	/Me	IF FEMALE:	23c. If yes, outcome of preg	gnancy				23d. Date of	of delivery	
Bo	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time o		Ectopic pregna Other <i>(specif</i> y			Month	,	Year
Ö	the d y the	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
Division of Vital Records, P.O.	w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medi	Part II. Other significant conditions of	ontributing to death but not r	esulting in the ur	nderlying cause	given in Part I.	23e. Did	obacco use contrib	ute to the ca	use of death?
sp	quire: n sig uld bu							1 🗆	Yes 2□No 3	Probably	4 ☐Unknown
ဝွ	s bee	olet						24a. Was		ire autopsy f	indings available
Re	The law cate has page 2	Completed						auto perfo	ormed? dea	ath? Yes 2	
ta	an: tifica tor, p	BeC	25. Was case referred to medical				26. Place of Dea				
<u> </u>	ysician: is certific director,	To B	examiner? 1 Tes 2 No	Hospital: 1 Impatient 2	☐ ER/Outpatien	t 3 DOA	Other: 4 Nursing H	ome 5 Resi	dence 6 □Other	(Specify)	
0	ig Ph ter th	ü	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. l	njury at Work?	28d. Describe	how injury occurred	J	
<u>.</u>	endir ath. or: Af	atlc	2 Accident investigation	1			1 ☐ Yes 2 ☐ No				
:≦	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre ocify)	eet, factory, off	ice	28f. Location (City or To	Street and Number wn, State)	or Rural Rou	ute Number,
٥	urs af urs af rat D	Ce									
	Hosp 24 ho Fune Fune tely fi	Medical		ysicien: To the best of my k							
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Mec	29b. Signature and title of certifier	and manner stated.		29c. Lic	ense number		29d. Pate signed (
	F 3 F 3	1	borke	Mo		カ	52035				
	10/2/		30. Name and address of person who	completed cause of death (I	tem 23a) (Type.				14.		2005
<u> </u>	V-0		BINU CHA UCO	291 Stone	w Ave	mie	Westa	ninista	NID	2/15	57
12	Sta Registi		31. Date filed (Month, Day, Year) APR 1 9	2005 Receiver's Sig	mature .	(med)					

-26	668			1 1000	St	ate of I	Marvia	nd / Den					lental Hy		a Legible.	
S			1 - For State Registrer		O.	Q10 01 1	, viai j ta	-	rtificat			2110	iornai i i	Reg. No	2001	5 1510
			1. Decedent's Name (F	First, Middle,	Last)								2. Date of De			3. Time of Death
	Physici /Medic		Sarah	Lynn		Raths							April	16,	2005	0632 a M
	Examir	ier	4a. Facility Name (If no 16835 Rii				er)				Location of	of Death		40	c. County of Dea	th
			5. Social Security Num		. Sex		Age (In vrs	. last birthday,	Germa	antor	WN If Under:	24 Hrs.	8 Date of Bi	rth I	Montgome	thplace (State or Foreign
	Funeral Director		135-52-00		1 □ M	2 ⊠ F	49	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Date of Bi Aug. 3	y Year,	55 Iow	thplace (State or Foreign ountry) a
	P .		Usual Residence of De	ocedent Ob. County			100.0	ity, Town or L								101111111111111111111111111111111111111
	shov	5	10a. State 10 Maryland	Mont	roma r	• • • • • • • • • • • • • • • • • • • •	100.0	Gaithe		œ						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	rect	10e. Street and Number		Somer	У		Gartine	10f. Zip					10g. Ci	tizen of What Co	
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28s-f show he Madical Examinar must be notified at	Funeral Director	13120 Bi	andon	Way					0878					nited S	•
	ems 2	ner	11. Marital Status			as Decede		U.S. 13.	Was Dece	dent of Hi	ispanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)	o-	14. Race - Ame Black, Whit	
36	or Ita	by Fu	1 Never Married		d 1	☐ Yes 2] Yes, Give	No No	i	1 ☐ Yes	**	Specify:	,	riodii, otoi,			hite
00	ture!	q pa	3 Widowed 4	. Decedent's		ear or Date)S:	16a Dece	dent's Usua	al Occupa	ation			16h K	(ind of Business	Andustry
715	within 72 ho iene, r then "natur the Medical	Completed	(Specify Elementary/Seconda	only highest	grade con	npleted)	or 5+)	(Give	kind of wo DO NOT u	rk done c	durina most	t of work	ing	100.11	and of Basiness	Middelly
212	10 m = **	Som	Liementary/Geodina	119 (0-12)		5+		Comme	rcial	Ext			orator	-	corator	
pu	et = 5	e e	17. Father's Name (Fir.										(First, Middle		,	
ryla	should ba nd Mental marked o matic eve	2	Herbert 1	_				19b Maili	na Addross	/Street			S. Sta		or Town, State, 2	Zin Codol
Maryland 21215-0036	id 2 sl Ith an 27 Is r traur		Herbert 7				ther	1	-						MD 2087	
d)	ages 1 and 2 should b ant of Haalth and Ments it: If item 27 Is marked y or other traumatic e		20a. Method of Dispos	ition		<u> </u>	20b.	Place of Dispo	osition (Nar	ne of	1		il 18,		ocation - City or	
Ë	Page nent c int: If		1 □ Burial 2 🔏 C `4 □ Donation 5 [al from Sta		tropoli	-		·	200		Alex	andria,	Virginia
Baltimore,	parmit. Pages 1 Department of H Important: If ite any injury or ot		21. Sign ture o Funer	al Service ti	cense	/			2. Name an			DC	Vol Fun			
	205 2 3		/~~	JE.	. Vi										ourg, MD	
8			23a. Part1. Enjer the c shock, or heart to Immediate Cause (Fin		mplication	use on each	sea the dea h line.	im. Do not en	er the mod	ie or dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Frysician /Medical		disease or condition resulting in death)	ai	a	Due to for	ACT as a conse		CHOT	W	OUND	96	HE	OF		
	Examiner			. 1	î.	10) 01 600	as a conse	querice or).								
	B 5	ner	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or injuthat initiated events	ions, diate	b. —	Due to (or	as a conse	quence of):								
	acuted and transi	Examiner	Cause (Disease or inju that initiated events resulting in death) Las	iry	c	D to /										
8760,	icate be executed physician and s the burial-transit	cal E	resulting in death, Ede			Due to (or	as a conse	quence or):								
687	law requires that the death certificate be executed as been signad by the attending physician and 2 should be detached for use as the burial-transit				d											
Box (death certifica attending pt d for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pro	egnant ;		yes, outcor			75-4:-						23d. Date of del	ivery
-	death	slcia	in the past 12 mo 1 ☐ Yes 2 ☐ N		4	☐Live birth ☐Pregnant ☐Unknowr	t at time of		Ectopic pr Other (sp						Month	Day Year
P.O.	that the de ad by the detached	Phy	9 AUnknown	at a sadition				andria e in about			in Death		22a Dida			the acres of death?
	ires tha signad d be det	by	Part II. Other significa	nt conditions	s contribut	ung to deat	n but not re	suiting in the u	naeriying c	ause give	en in Part I.		230. Dia 1			the cause of death?
Records,	w requir been si should	ompleted								-			24a. Was			topsy findings available
Re	The lav ate has page 2	omo											autor	osy ormed?	prior to death?	completion of cause of
Vital		Ое	25. Was case referred	to medical							26. Place	of Death	1 X Yes	2□ No	1 🗷 Xes	2 □ No
Ž	d is	To B	examiner? 1 □ Yes 2 □ No		Hospit	al: 1 ☐ Inpa	atient 2	ER/Outpatier	nt 3 DC	Othe	or. 4 🗆 Nur	rsing Ho	me 5□Resi	dence	6 XOther (Spec	city) at scene
n of	ng fter fter	on:	27. Manner of Death 1 □ Natural 5	i Pending			Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe		ry occurred	E
Sio	r Attending er death. rector: Afte by the fune	icatl	2 ☐ Accident 3 ☑ Suicide	investigat	he	411610					res 2 🔯					ral Route Number,
Division		ertification:	4 Homicide	determine	ed 20	building,	etc. (Spec		eet, ractory	r, onice			City or To	vn, State)	ANTOWN MD
	ne Hospitel or Attendi n 24 hours after death. ne Funerel Director: A pletely filled in by the fo	O	29a. Certifier 1	Certifying	Physicien	: To the be	st of my kn	owledge, deat	n occurred	at the tim	e, date and	place,	and due to the	cause(s)	and manner as	stated.
	To the Hospitel or within 24 hours after to the Funerel Dir completely filled in	edical	(Check only 2[one)	X Medical Ex	eminer: C	On the basis	s of examin	ation and/or in				h occurr			d place, and due	
	To the h within 24 To the F complete	Σ	29b. Signature and title	of certifier						. License	number				te signed (Montl	*
	PP		P 911	OD.						CME		100		Apr	il 16,	2005
	-		30. Name and address		o complet		of death (Ite	m 23a) (Type,		11 Pa	enn S	tree	t Rol+	imor	re Marri	land 21201
Let's	Sta	te	31. Date filed (Month, I	Day, Year)			strar's Sign	ature		I(<u> </u>	-166	с раті	נטווע.	e, rary	14110 21201
	Registr		AP	R 19	2005	die	440	b A	CHEL							

			For	State of Ma	ryland / D	Рера	rtment	of H	ealth a	ind M	ental Hy	gien	e e	
			State Registrar			Cen	tificate	of L	Death			Reg. No	2005	15188
	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of De Month	Da		3. Time of Death
	/Medic	al.	Agnes Marie Russe				4b. City, T	own. or	Location o		April 1		2005 c. County of Deat	11:57 P ^M
ĺ	Examin	er	Anne Arundel Medic				Annap						ne Arund	
	Funeral		Social Security Number 6. Sex		(In yrs. last birt		If Under 1	Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year	9. Birt	hplace (State or Foreign untry)
	Director		265-42-4562 Usual Residence of Decedent	JM ZLA	86	Yrs.					10/03/1	1918	Penr	nsýlvania
	/land		10a. State 10b. County		10c. City, Town	or Loc	ation				-			10d. Inside City Limits
	a-f sh	ctor	Maryland Prince G	eorges	Bowie									1 X Yes 2 No
	vith the	by Funeral Director	10e. Street and Number				10f. Zip (-	itizen of What Co	untry?
	eath v	erai	2200 Penfield Lane	2 12. Was Decedent E	ver in U.S.	13. W	2071		spanic Orio	nin? (Spe	cify Yes or No	USA	14. Race - Ame	ncan Indian.
က	or Item	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱N						, Puerto F	cify Yes or No Rican, etc.)		Black, White	
ğ	ural', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			Yes 2		Specify:				Specify: Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "ratural", or items 23a or 28a-f show the Madical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a.	Give k	ent's Usual and of work O NOT use	Occupa done di retired)	tion uring most	of workir	ng	16b. h	Kind of Business/	Industry
212	y withi	ошь	Elementary/Secondary (0-12)	College (1-4or 5- 4		each		,				Edu	cation	
밀	al Hyg	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	, Maidei	n Sumame)	
yla	Ment Marked Marked	2	Steve McDonald						Agne					
Maryland	d 2 sh th and ths m traum		19a. Informant's Name/Relationship (Ty Thomas W. Russell								i <i>H</i> oute Numb ie, MD		or Town, State, 2 16	(ip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importants if item 27 is marked other than "natural; or Items 23a or 28a-f show any highry or other traumatic event, the Medical Examinat must be notified at one injury or other traumatic event, the Medical Examinat must be notified at one.		20a. Method of Disposition		20b. Place of	Dispos		e of			ate ate		ocation - City or	Town, State
<u>i</u>	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Nation An	ílin lai	gťon Cemet	ery		/20/	2005	Arli	ngton, V	/irginia
Baltimore,	permit. Departi Import any Inj once.		21. Signature of Funeral Service Livens	86		22.	Name and	Address					ns Funer	al Home
	40 = 8 A		23a. Part1. Enter the disease, or compl	ications that caused	the death. Do r								D 20715	Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	D.		,		,		, , , ,	,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence		071	6						
	Examiner	-	Sequentially list conditions,	Due to (or as a	1 consequence of	of):								
	ted s insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 43 1	2001304001100	017.								
o,	cate be executed physician and the burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence of	of):								
8760,	physicist the pu	dicai		J										
9 X	death certifica e attending ph d for use as t	/Ме	IF FEMALE:	3c. If yes, outcome	of pregnancy								23d. Date of deli	verv
. Box	death e atter d for L	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 100 × 100	1 ☐ Live birth : 4 ☐ Pregnant at			Ectopic pre Other (spe						Month	Day Year
P.O.	res that the de signed by the a be detached f	Physician/Med	9 Unknown	9Ll Unknown							ag: Bid:			4
ds,	signed bed	by	Part II. Other significant conditions con	ithbuting to death bu	it not resulting in	i the un	denying cai	use give	nın Panı.		1 0	1		the cause of death?
ecords,	law requires as been sign 2 should be	iete									24a. Was	an	24b. Were au	topsy findings available
Ξ	9 2 9	Completed									autor perfo	ormed?	death?	completion of cause of
Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?:							of Death	(Check only o	>-/		
of \	8 5 7	٦.	1 ☐ Yes No	lospital: 1 Impaties 28a. Date of Injur		tpatient			4 Nul		ne 5 Resident		6 Other (Spec	cify)
	ding h. After fune	tion	1 Actident 5 Pending investigation	(Month, Day		njury	м 20	ic. Injury Work 1 🗆 Y	? 'es 2 □ N		. 0030,100	now inju	ny occurred	
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju		rm, stre	et, factory,	office		2	8f. Location (S City or Tox			ral Route Number,
ā	urs after oral Direction by													
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical	29a. Certifier Sertifying Physical Check only one)	sician: To the best of ner: On the basis of and manner sta	examination and									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	11			29c.	License	number	-		29d. Da	ate signed (Month	n, Day, Year)
			1 Chi	U.,	MO		7	55	18	+		,4	116/0	05
			30. Name and address of person who co	Ty .	A	(Type, F	Print)	A.	-12	10	M.	ed.	. (is ter
	Sta Registi		31. Date filed (Month, Day, Year) APR 18 2	005 32. Figistra	r's Signature	A	Soul	,						

permit. Fages I and a should be lived within 2 hours after death with the Maryland Hold with the Maryland I had a should be lived with the Maryland I had a should be shown any injury or other traumatic event. It a Maryland Examination of the market of the maryland any injury or other traumatic event. It a Maryland Examination of the market of the maryland and injury or other traumatic event. It a Maryland Examination of the maryland and injury or other traumatic event. It a Maryland Examination of the maryland and injury or other traumatic event. It a Maryland Examination of the maryland and injury or other traumatic event. It a Maryland in the maryland and injury or other traumatic event. It a Maryland in the maryland injury or other traumatic event. It a Maryland injury or other traumatic event. It is not of the maryland injury or other traumatic event. It is not of the maryland injury or other traumatic event. It is not of the maryland injury or other traumatic event. It is not of the maryland injury or other traumatic event. It is not of the maryland injury or other traumatic event. It is not of the maryland injury or other traumatic event. It is not of the maryland injury or other event. It is not of the maryland injury or other event. It is not of the maryland injury or other event. It is not of the maryl	5. U										Month	Day			_ M
Examiner Funeral Director	5. U	THE CA	If not institution								4	12	0.	5 3:2!) a"
Director	U			, give street and n	umber)		4b. City,	Town, or	Location of	of Death		4c.	County of D	eath	
Director	U	Social Security N	SEY HOU		T= . "			VILI 1 Year		24 Hrs			ONTGO		
3a or 28a-f show	-	119-01-0	593	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 87		Months	Days	Hours	Min.	8. Date of Bir (Month, Da 12/17/			Birthplace (State Country) EW YORK	or Foreign
3a or 28a-f shall be notified.		sual Residence o Da. State	10b. County		10c. C	ity, Town or L	ocation							10d. Inside	City Limits
3a or 28s		MD	MONTGO	MERY	RO	CKVILI	E							1 □ Ye	s 2 No
38	10	De. Street and Nu	ımber		•		10f. Zip					_	zen of What	Country?	
22 62		6111 MO	NTROSE	ROAD #32				208					S.A.		
al', or Items	1	 Marital Status Never Man ™Widowed 	ried 2 Marr 4 Divorced	Armed I	2 No live	J.S. 13.	Was Deced If Yes, spec 1 ☐ Yes — 2		spanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	1		vmerican Indian, ∤hite, etc. HITE	
ical E		/600	15. Decedent	's Education	<i>(</i>)	16a. Dece	dent's Usua kind of wor	al Occupa	ation	t of work	na	16b. Kir	nd of Busine	ss/Industry	
ygiene. ner than "natur. t. the Medical I	-	Elementary/Sec		college	(1-4or 5+)	life.	DO NOT us	se retired)	O WOIN	ing			_	
Con		12	<i>(</i> 5)			ADM	IN. AS	SSIST		d- N	(Fire A Adid die		S. GO	VT.	
arked out		7. Father's Name WILLIA	(First, Middle, M GELB								(First, Middle SCHIFFM		Sumame)		
raumar		9a. Informant's N		hip (Type, Print) L — DAUGH	TPD		•				ADT TNO			e, Zip Code) NIA, 22.	202
Ther 1	20	Da. Method of Dis		- DAUGH	20b.	915 Place of Disp	sition (Nan	ne of	1		ate			or Town, State	202
1: H it	-			3 □Removal from		cemetery, cre TIONAL	matory or o	ther place		. /1/.	/2005		S CHU		
artme ortani injury	2	1. Signature of R	5 Utner (S)	Decity) Licensee	INA		2. Name an				2005 ATIONAI		7.51		
Depar Impo any ir	1	Little	3000	and a	3 (-	7	482 T.	EE H	IGHWA		LLS CH				
ysician	fi	23a. Part1. Eder shock, or hea mmediate Cause lisease or condition	(Final	complications that only the cause on	caused the dea each line.	th. Do not en	ter the mod	e of dying						Approxim Interval B Onset an	etween d Death
/Medical	r	esulting in death)			o (or as a consec		S INOM	A						HOMIN	<u> </u>
physician and strength and stre	c C th	dequentially list contains. Enter Undiause. Enter Undiause (Disease on the initiated event asulting in death)	erlying r injury	Due to	o (or as a consec	quence of):			7/	1	1	ns/EFi		1 YEAI	R
as been signed by the attending physicia 2 should be detached for use as the bur pleted by Physiclan/Medical		FEMALE:		d	utcome of pregn	ancy	(ERIFIC	APPA CITA	(VED BY	MEDICAL EXAM		2d Data of	deline	
detached for use as the detached for use as the property of the second o	2	3b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?	1 Live	birth 2 Feta gnant at time of o	al death 3	□Ectopic pro □ Other (sp		/				3d. Date of Month	Day	Year
be d				ons contributing to	death but not res	sulting in the u	nderlying ca	ause give	en in Part I.				2 1	e to the cause o	
should should	-	LEFT HI	I TRACI	AKE	· · · · · · · · · · · · · · · · · · ·							Yes 25	•		
page 2											1 ☐ Yes	osy rmed? 2 X No			
		5. Was case refe examiner? 1 \(\sum \) Yes 2 \(\sum \)		Hospital:	Inpatient 2	TER/Outpation	nt 2 🗆 🗠	Othe			n <i>(Check only c</i> ne 5 ☐ Resid	I		E CASEY	HOUSE
重量 一	100	7. Manner of Dea	ith	28a. Dat	of Injury	28b. Time o		8c. Injury Work			28d. Describe		Other (S	poolig/	
death. ctor: After y the funer flcation;		2 XAccident	5 Pendin investig	gation 04/0	9/2005	0400	а м	1 🗆 1	res 2X	No	Subject	t fel	1		
al Diractor: After led in by the funers Certification:		3 Suicide 4 Homicide	6 🗌 Could r determ	ined 286. Place	ce of Injury - At h ding, etc. <i>(Speci</i> sing Hom	fy)	reet, factory	, office			28f. Location (S City or Tov 6001 Ma	Street and vn, State) mcas	Rocky ster M	ill Rd.	mber,
To the Funeral Director: completely filled in by the		9a. Certifier (Check only one)		g Physician: To the	ne best of my kn	owledge, deal					and due to the	cause(s)	and manner	as stated.	(s)
omple omple	2	9b. Signature and	title of certifier				29c	. License	number			29d, Date	signed (Me	onth, Day, Year)	
- 0 →)	£. (1	PI	Bie	MD	D	0947	70		1	APRII	12,	2005	
	3		ress of person	who completed ca		m 23a) (Type,					CUT AVE 20895		,		
State	3	Date filed (Mor			Registrar's Sign	ature				,					

		1- For State of Maryland / Department Certificate		Reg	ene 1. No. 2005	15100
Physic /Medi		Decedent's Name (First, Middle, Last) LOYAL EDWARD STEVICK		2. Date of Death Month APR 2	7 2005 Year	3. Time of Dealer 6:11 A M
Examii		NATIONAL NAVAL MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		8. Date of Birth	4c. County of Death MONTGO 9. Birth	MERY
Funeral Director		174-28-6977	Days Hours Min.	July 11,	1937 Penn	sylvania
the Marylan 28e-f show	ector	10a. State 10b. County 10c. City, Town or Location Maryland St. Mary's Le: 10e. Street and Number 10f. Zip C	xington Park	100	g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "netural; or itama 23s or 28s-f show other treumatic event, the Madical Examiner results he natified at	by Funeral Director	20005 Tippett Road	20653 Int of Hispanic Origin? (Spe y Cuban, Mexican, Puerto I	Ţ	United Sta 14. Race - Amer Black, White Specify: Whi	tes ican Indian, , etc.
thin 72 hours e. an "netural	Completed	15 Decedent's Education 16a Decedent's Usual	Occupation done during most of working retired)	ng	5b. Kind of Business/II	
ould be filed wi Mental Hygien arked other th	Be	17. Father's Name (First, Middle, Last)	e Mechanic 18. Mother's Name			nment
12 should be h and Mental 7 is marked of treumatic eve	To		Street and Number or Rura	I Route Number, (City or Town, State, Zi	
ages 1 and 2 ant of Health at: if item 27 y or other tr		Patricia Ann Stevick / Wife 2005 Tippe 20a. Method of Disposition 1	er place)	Date 20	ark, Mary1 Oc.Location - City or T har1otte H	own, State
permit. Pages Department of Pimportant: if ite any injury or of once.		21. Signature of Timeral Septice House 22. Name and Edward N. Brinsfield, Jr. M00052 22955 Ho	Address of Facility Bri	insfield d, Leona	Funeral H	ome, P.A.
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. pneumonia resulting in death)	of dying, such as cardiac o	or respiratory arres	it,	Approximate Interval Between Onset and Death
that the death certificate be executed that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical Examiner	Due to (or as a consequence of): Cause Disease or injury that initiated events resulting in death) Last	phoma			
the death certifica the attending ph ched for use as th	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specially 1) □ Unknown			23d. Date of dein Month	very Day Year
	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying car	use given in Part I.		cco use contribute to	the cause of death? bably 4 □Unknown
The law ate has b page 2 si	Completed			24a. Was an autopsy performe 1 Yes 2	prior to condeath?	opsy findings available ompletion of cause of 2 🕅 No
Attending Physicien: Th r death. ector: Atter this certificate by the funeral director, pag	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	and the second s		ce 6 □Other (Spec	ify)
e Hospitel or Attending 124 hours after death. e Funeral Director: Afte letely filled in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
the Hospitel or Ai in 24 hours after of the Funeral Direct pletely filled in by	edical	29a. Certifier (Check only one) 1 ▼ Certifying Physician: To the best of my knowledge, death occurred at 2 □ Medical Examiner: On the basis of examination and/or investigation, i and manner stated.	in my apinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
To the To the Complete Complete	2		License number 101236858 (VA	(<i>F</i>	April 27	2005
102,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COREY A. CARTER LT MC USNR	NATIONAL BETHESDA		DICAL CFN -5600	EK
St Regist	ate trar	31. Date filed (Month, Pay Year) APR 2 9 2005 32. egistrar's Signature				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** April 16, 2005 5:33 P. Schneider John LaVerne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. 14, Director 216-22-0008 76 June 1928 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show ir than "natural", or itams 23a or 28a-f showing Medical Examinar must be notified at 1X Yes 2 No Directo Montgomery Maryland Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1306 Veirs Mill Road 20851 USA filed withIn 72 hours efter death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Tree Trimmer Tree Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event once. Be Schneider Lillian Blundon 2 Frank C. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 902 Allan Road Rockville, Maryland 20850 Shirley Shelhorse / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 21. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 2005 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee Gaithersburg, MD 20877 VIO E. Deer Park Dr. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Myocardial Infarction 1 Hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Vascular Disease Years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has certificate or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 일 1 ☐ Yes 2X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending 1 X Natural 1 Yes 2 No investigation death. 2 Accident Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier MO D39177 April 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive Olney, Maryland 20832 Curtis W. Ollayos, M.D. 39. Registrar's Signature 31. Date filed (Month, Day, Year) State 20 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

in realing and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show the marked other traumatic avant, the Medical Examiner must be notified at traumatic avant, the Medical Examiner in the modified at the mod	n I r	1. Decedent's Name (First, Middle, La Bernice 4a. Facility Name (If not institution, give Garrett County M	Maxine	<u> </u>				g. No. J		
/Medica Examine Funeral Director	r	4a. Facility Name (If not institution, given	Maxine			1	2. Date of Death			3. Time of Death
-uneral Director					Sweitzer		Month April		Year 005	4:32 P
irector		Garrett County M			, ,	or Location of Death		4c. County	-	
irector						Oakland If Under 24 Hrs.	O. Data of Birth		Garre	
oms 23a or 28a-f show ir must be notified at	-	215-20-7069	Sex 7. Age 1□M 2፟፟ I F	(In yrs. last birthday) 80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 21,			e (State or Forei) 1and
oms 23a or 28a-f	=	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d	. Inside City Limi
r must be n	5		rrett		1.2.2	0akland				
r mus	5	10e. Street and Number 3771 Gorman Road			10f. Zip Code	21550	10	g. Citizen of V	vnat Country USA	77
동날	2	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H		city Yes or No-		- American	Indian.
al', or ite		1 ⅓ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:)	If Yes, specify Cub: 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spetan, Mexican, Puerto F Specify:	Rican, etc.)		k, White, etc	
"natura fealcel	completed by	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of workin d)	1	6b. Kind of Bu	siness/Indus	stry
n and Mental Hyglene. 7 is marked other than " reaumatic avant, the Me.		Elementary/Secondary (0-12)	College (1-4or 5+)	ssistant			Fruit	Mark	o.t
otha vant,	ם פ	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M			et
s markad of	2	Franklin	Pierce	Swei	tzer	Alta	Mabe	1	Fitzwa	ter
s ma	1	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number,	City or Town,	State, Zip Co	ode)
ar tra		Michael Steyer/	nephew	563	N. Lemoy	ne King R	oad, Oak	land,	Md. 21	550
Department of Health's Important: If itam 27 is any injury or othar tra		20a. Method of Disposition	75 16 0	20b. Place of Dispo	osition (Name of matory or other place	ce) Da	ate 2	0c. Location -	City or Town	, State
T O		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		1		Gdns 4/23	/05	akland	MJ	21550
inju inju	-	21. Signature of Funeral Service Lice	ngee M		2. Name and Addre			S. Se	•	
Impo any ir		Day Obs	H. Worker	S	rewarr bu	neral Home		kLand,		
rsician ledical aminer		23a. Part1. Enter the disease, or co- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Myocardia	al Infarct	ion	ng, such as cardiac or		st,	in in	pproximate terval Between nset and Death
he burial-transit	LYG	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):						
phys s the			_ d							
detached for use as the	ompleted by rilysiciallymed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	∃Ectopic pregnancy ∃ Other (specify) _	/		23d. Date Mor	e of delivery nth Da	y Year
signed to	2	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	acco use contr	ibute to the o	ause of death?
uld bu	2	Adenocarcinoma	Ovary				1 ☐ Yes	2 □ No	3 🙀 Probabl	y 4 ∐Unknov
should should	20	COPD					24a. Was an	24b. V	Vere autopsy	findings availab
his certificate has but I director, page 2 s		COLD					autopsy perform	ed? d	rior to compl eath?	etion of cause of
ficate or. pa) _	OC Was seen referred to a refinal					1 Yes 2		☐Yes 2[] No
certi		25. Was case referred to medical examiner?	Hospital:		oth	26. Place of Death				
this or		1 XYes 2 No 27. Manner of Death	1 28a. Date of Injury		IL 3L DOA	4 Nursing non				
To the Funeral Director: After th completely filled in by the funeral	27. Manner of Death 1 Renatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined for experiment. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occur M 1 Yes 2 No 28d. Describe how injury occur									eute Alumbar
at Dirac		4 Homicide determined	building, etc.	(Specify)	est, factory, office		City or Town,			
To the Funeral Director: completely filled in by the	calcal	29a. Certifier 1 ☐ Certifying PI (Check only one) 2 ☑ Medical Example (Check only one)	nysician: To the best of miner: On the basis of e and manner state	xamination and/or in	h occurred at the tir vestigation, in my o	me, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	use(s) and mai te and place, a	nner as state ind due to the	d. e cause(s)
Toth	E	29b. Signature and title of ce offier			29c. Licens	e number	290	d. Date signed	(Month, Day	v, Year)
)				Н26154		4/20	/2005	
		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)					
0	1	P. Daniel Mill	er D.O. 6	69 Wolf Ac	res Drive	e, Oakland	. Md. 21	1550		

			For State Registrar	State of Ma	aryland		artment of I		and Men		ene g. No.2	105	15193
			Decedent's Name (First, Middle, Las	t)						Date of Death	1		3. Time of Death
	Physici		Mary	Silva						Month	^{Day} ⁵	Year 2605	23:10 PM
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location o	f Death	/	4c. Count	y of Death	
1	LAGITIII		Anne trindel	Medical	Cen	ta	Ann	apol	15,		Ann	e Ar	endel
	Funeral		Social Security Number 6. Security Number	- Mr.	e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. [Min.	Date of Birth Month, Day,	Year)	9. Birthpl Coun	ace (State or Foreign try)
	Director		557-88-3194	53		Yrs.			Au		1951	Cali	fornia
	and .		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation		,			10	Od. Inside City Limits
	Aarylan I show	ō	Maryland Anne Aru	nde1				Edgewa	ater			l	1 ☐ Yes 2√∑ No
	28a-	Director	10e. Street and Number	Idei			10f. Zip Code	Dagewi	acer	10	og. Citizen of	What Coun	
	With Be or		3907 Westshore Dri	ve			210	37			Unite		*
	72 hours after death with the Maryland 'natural', or iteme 23e or 28e-1 show disal Examinar must be redified at	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Orig	gin? (Specify	Yes or No-		ce - Americ	
9	after or ita	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 N If Yes, Give	10	1	1 ☐ Yes 2 ☒ No		, Puerto Rica	n, etc.)		ack, White, e	ite
21215-0036	ral',	d by	3 Widowed 4 Divorced	Year or Dates:							Speci	ny: 1122	
5	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	1	6b, Kind of B	Business/Ind	lustry
121	within ene. than "	ш	Elementary/Secondary (0-12)	College (1-4or 5	i+)		ng Devel			ialisi	F	USDA	
2	filed withi Hygiene. othar than		17. Father's Name (First, Middle, Last)			TEATH	ing bever		r's Name (Fir				•
Maryland		Be c	William Delong						phine				
7	2 should be and Mental is marked aumatic ev	2	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailie	ng Address (Street	1			City or Town	n, State, Zip	Code)
S	nd 2 salth ar		John R. Silva / Hu	shand		3907	Westshor	e Driv	ve Ed	rewate	r. MD	21037	
ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of matory or other pla		Date		0c. Location		
e E	0 0		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		-	ematory		/22/20	05 B	ältimo	ore, M	aryland
Baltimore,	artr artr		21. Signature of 51 , ral Service Usen	7		22	2. Name and Addre	ess of Facility	y John	M. Ta	vlor E	unera	1 Home, Inc
m	Departiment once.		1/1/1/1/1/1			14	77 Duke o	f Glo					MD 21401
	Pnysician /Medical Examiner	her	23a. Part. Enter the disease, or compshock, or heart failure. List only of the composition of the compshore that disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause.	aDue to (or as a	a consequ	nence of):			ance				Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequ	eence of):							
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	⊒Ectopic pregnand ⊒ Other (specify) _	y				ate of deliver onth	ry Day Year
rds, P	quires that in signed t	by	Part II. Other significant conditions co	ontributing to death bu	ut not resu	ılting in the u	nderlying cause gr	ven in Part I.		23e. Did tob	1	ntribute to th	e cause of death? ably 4 Unknown
Records,		Completed								24a. Was an autopsy perform 1 Yes 2	/	prior to con death?	esy findings available apletion of cause of
Vital	nysician: Th nis certificate I director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death (Ch	eck only one)		
of V	S S	은	1 ☐ Yes 2√2 No	Hospital: 1 Inpatie		ER/Outpatier	IL 3 DOA		rsing Home	5 Resider	nce 6 🗆 Ot	her (Specify)
	Jing After fune	ation:	27. Manner of Death 1 Satural 5 Pending 2 Accident investigation		ry y Year)	28b. Time o Injury	Wo	ry at ork?] Yes 2 □ h		Describe how	w injury occu	rred	
Division	tal or Attandi rs after death. al Diractor: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At ho c. (Specify	me, farm, str	reet, factory, office			Location (Str. City or Town,		ber or Rural	Route Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funeral Diractor: Afte completely filled in by the fune	Medical		ysician: To the best on niner: On the basis of and manner sta	examinat					t the time, da	te and place	, and due to	the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	1/1.1.	11/		29c. Licen	se number	0~ (29	d. Date sign	ed (Month, L	Day, Year)
•			* Mara 7	REXIVI	//-		120	051	713		4	16/	05
			· ·	completed cause of de	eath (Item	23a) (Type,	Print) c Rq S	. .	1		11		- (-1
			SARA L- HORTON				c Kq J	211	Ann	apolis	M) 21	401
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 9	2005 32. Reffstra	ars Signat	A P	good						

			State of Maryland				Mental Hyg	iene	1 570
<			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eath	2. Date of Dear		3. Time of Death
	Physicia /Medic		John Schmidt, 11				April 1	7 2005	
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I		1	4c. County of Dea	imore
	Funeral		15 Hunt Chase Court 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year	i more If Under 24 Hrs.	8. Date of Birth	9 Bi	Thplace (State or Foreign ountry)
	Funeral Director		212-42-4464 XM 2 F 61	Yrs.	Months Days	Hours Min.	Oct. 2	7, 1943	MD
	land ow			Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show	ctor	MD Baltimore	I	Baltimore				1 ☐ Yes 2 🔯 No
	with th	Funeral Director	10e. Street and Number 15 Hunt Chase Court		10f. Zip Code	20	1	0g. Citizen of What C	
	eath v	erai	11. Marital Status 12. Was Decedent Ever in U.S.	13.1	2120		ecify Yes or No-	US 14. Race - Am	
0000	or fre	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban I □ Yes 2 X No	Specify:	Rican, etc.)	Black, Whi	White
5	72 hours 'natural', olcal Exa	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupat	uring most of wor.	king	16b. Kind of Business	/Industry
V	within ene. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	mputer Pr			Johns Ho	
שמ	filed within I Hygiene. Other then	a)	17. Father's Name (First, Middle, Last)					Physics : Maiden Sumame)	Lab
lan I	2 should be and Mental is marked aumatic ev	To B	John Paul Schmidt, Jr.			Larue H	Helm		
Mar)			19a. Informant's Name/Relationship (Type, Print)					, City or Town, State,	Zip Code)
e)	s 1 and f Health item 27 other tr		Karla D. Schmidt/Wife 20a. Method of Disposition 20b. Plac	ce of Dispo	Iunt Chase			ce, MD 21, 20c. Location - City of	209 Town, State
Ē	Peges nent of int: If it iry or o		1 🗆 Bunai 2 💢 Cremation 3 🗆 Removal from State		natory or other place rematory	Apı	2005	Baltimore	, MD
Бант	permil. Pege Depertment of Important: If any injury or QDC®.		21. Signature of Fyneral Service Licensee	22 E	Name and Address	Sons, E	A. Seve		Fineral Home
			252 Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						Approximate Interval Between
240	Physician /Medical Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying	ince of):	dtomo	outh Se	elf-int	licted	Onset and Death 5 m:numes
68/6U,	sician: The law requires that the death certificate be executed certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last c	nce of):		¥9			
O. BOX	the death certifica by the attending phached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	léath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
ras, r	The law requires that the tee has been signed by the bage 2 should be detache	ρ	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause giver	n in Part I.		pacco use contribute t es 2 □ No 3 □ P	o the cause of death?
VItal Records	The law re cate has bei page 2 sho	Completed					24a. Was a autops perform	y prior to	utopsy findings available completion of cause of s 2 No
<u> </u>	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:		Othor	r	th (Check only on	<u> </u>	
ō	Phys or this oral dri	. To	27. Manner of Death 28a. Date of Injury 2	8b. Time of	28c. Injury	4 □ Nursing H		ow injury occurred	ecify)
0	Attending it death. actor: After by the fune	atio	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation April 17,2005	837A	Work′ M 1 □ Y		Gun Shot	Tomouth -	sefficialisted
DIVISION	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)		eet, factory, office		28f. Location (St City or Town 5 HUN	reet and Number or R State) State CHASE CT. SUILLE, N	ural Route Number,
	Hospi 24 hou Funer Funer tely fill	edicai	29a. Certifier 1 Certifying Physician: To the best of my knowl (Check only one) Medical Examiner: On the basis of examinatio and manner stated.						
	fo the within i To the	Med	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
			Light MD Debut	1	1018	3667	A	18:19	2005
		_	30. Name and address of person who completed cause of death (Item)	3a) (Type,	Print)	(1)		pril 18,: laryland	21402
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	m 51 €	411 CI.	Luthon	sile M	aryland	<1042
	Registr		APR 1 9 2005	E A	medi				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Helen C. Shrout 2005 APRIL 28 0319 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 233-66-5731 Yrs 86 09/09/18 **Director** WV Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at WV Mineral 1 TyYes 2 □ No Keyser Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or E Street 316 S. 26726 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or Itams 11 Marital Status filed within 72 hours after 1 Yes 22000 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: þ 3X Widowed 4 □ Divorced white 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othin any injury or other traumatic event OREs. Be Peter Muzyn Kathryn Mendelowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. David Shrout/son Rt.4Box 69, Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 05/03/05 Queen's Point Keyser, WV ⁴ □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Markwood Funeral Home, 21. Signature of Funeral Service Licensee Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 912, Keyser, WV 26726 Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CHRONIC RENAL INSUFFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably A ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No INFLUENZA TYPE B INFECTION 24a Wasan autopsy certificate 2 🔯 No 1 Yes Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 🕽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10059987 Va 30. Name and address of person who completed clause of death (flem 23a) (Type, Print) Rustopher DR. CHRISTOPHER VAGNONT 600 MEMORIAL AVENUE CUMBERLAND, MARYLAND 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryla			of Health of Death			iene	05	15196
	Physici	ian	Decedent's Name (First, Middle, Last)	SLONA	VER)		2.	Date of Deat Month	h Day	Year	3. Time of Death
	/Medi Examir	cal	BESSIE M 4a. Facility Name (If not institution, give		N LIN		wn, or Location	of Death	_4	4c. Cou	a 2005 nty of Death	4:40 AM
	Examir	ier	St. Cutherine's Nursin	/		Emmit					erick	
	Funeral Director		5. Social Security Number 3.17-05-5031 Usual Residence of Decedent	7. Age (In yrs	. last birthday) Yrs.	Months D	Year II Under Days Hours	Min. N	(Month, Day,	Year)	9. Birthol Count	ace (State or Foreign try) Limin PA
	ryland how		10a. State 10b. County	_	ity, Town or Lo	ocation					10	Od. Inside City Limits
	Ba-fs	ecto	PA Adams	60	thysburg	10/ 7: 0				0.000		1 ☐ Yes 2 🖪 No
	a or 2	Dir	1365 York RA			10f. Zip Co	312			U-S-A.	of What Coun	try :
	ems 2	nera		12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent	t of Hispanic Or Cuban, Mexica	rigin? (Specif	y Yes or No-	14. R	ace - America lack, White, 6	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show important: If item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Mudical Eventinal remained and once.	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷	No Specify			Spec	city: Whit	2
-5	n "nat	plete	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Dece (Give life.	dent's Usual C kind of work o DO NOT use r	occupation done during mos etired)	st of working		16b. Kind of	Business/Ind	ustry
N	filed with Hygiene other tha	Completed	\$	College (1-4or 5+)	Seu	mstress					tactor	1
Maryland	should be file nd Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Emunuel E. Tressle	r			Lill	lie Vir	first, Middle, N	igenbr	ode	,
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ty Virginia M. Riley -	po, Print) Daughter	19b. Maili	2 12	ver St. G			City or Ton	m, State, Zip	Code)
	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b.	Place of Dispo	The second second	of .	Date			n - City or Tov	vn, State
Baltimore	Pages ment of ant: If it		1 ■ Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)	lemoval from State Oak	8	emovial G	1 . 1	4-28-6	2005	Gethys	oung PA	19325
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licens Plank Mul	po W	22 1 (ddress of Facili	Call Control	Carlotes	t. Geth	lyburg th	14325
	cate be executed /Medical Examiner the burial-transit	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection) Due to (or as a consection)	quence of):	~	unco					Interval Between Onset and Death
.O. Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, oùtcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregn Other (specif					Date of deliver Month	y Day Year
ds, P.	uires that the de signed by the lid be detached	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying caus	e given in Part I	l.	23e. Did toba		-	cause of death?
Records,	The law requir sate has been si page 2 should	Completed	-1	· ·					24a. Was an autopsy perform	ed?	prior to com death?	sy findings available pletion of cause of
Vital		BeC	25. Was case referred to medical examiner?				26. Place	e of Death (C	1 ☐ Yes 2 Theck only one	De No	10 105 2	- NO
of V	shys this al dii	P	1 ☐ Yes 2 No		ER/Outpatier			ursing Home				
	ding After fune	tion	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M 200.	Injury at Work? 1 ☐ Yes 2 ☐		. Describe hov	w injury occi	urrea	
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, of	fice	28f.	Location (Str. City or Town,	eet and Nun State)	nber or Rural	Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C		sician: To the best of my kn ner: On the basis of examinand manner stated.								
	To the vithir To the comp	Me	29b. Signature and title of certifier				cense number	21	29		ed (Month, D	ay, Year)
			Sound	my 1.	W)	1	5839				2-02	
	17		30. Name and address of person who co		m 23a) (Type,	Print	USE	Ave	Fie	deri	ch. Mo	21701
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2 2	32. Registrar's Sign	ature	books		,,,	, , , , ,			

			For State	State of Maryland	d / Depa			Mental Hyg	iene	15 15107
			Registrar 1. Decedent's Name (First, Middle, Last)		tinoate or	Douth	2. Date of Dea	eg. No. ⊆ U €	3. Time of Death
	Physici	an			01 - 4			Month April	Day Y	ear
	/Medio Examin		Virginia 4a. Facility Name (If not institution, give		Clai		or Location of Death	Aprir	16 2005 4c. County of	
	Exami	iei	5559 Gloucester A	·		Churc				Arundel
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		. Birthplace (State or Foreign
	Director		217–42–3513	^{™ 2} ∏ ^F 61	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) May 25	71943 V	Vash., D.C.
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10- 6	Town out o					
	anyla shov	5			, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Me M	ectc	MD Anne Aru	ındel		Churc	hton		0.02	
	with t	늅	10e. Street and Number			10f. Zip Code		,	0g. Citizen of Wha	at Country?
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23s or 28s-1 show ent, the Medical Examinational be inclified at	Funeral Director	5559 Gloucester A	VENUE 12. Was Decedent Ever in U.S	13 1	20733		ecify Voe or No-	USA 14 Bace -	American Indian,
	ter d	Ę	1 ☐ Never Married 2 ☑ Married	Armed Forces?	13.	f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		White, etc.
Š	al', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2💢 No	Specify:		Specify:	white
5	2 ho	Completed	15. Decedent's Edu	cation	16a. Deced	tent's Usual Occup	oation	rin a	16b. Kind of Busin	
-	thin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	during most of work d)	ang		
7	od wil	Con	9		conve	nience s	tore cler	k	retail s	store
3	d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
<u>8</u>	Men Men arke	္	William Joseph	Mohler			Dorothy	Irene	Reid	
g	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Ifem 27 Is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, I'n Medical Examinational Carolilles and other traumatic event, I'n Medical Examinational Carolilles and I carolilles and		19a. Informant's Name/Relationship (Ty	,			and Number or Rur			
= ນັ	s 1 and 2 of Health item 27 I other tra		Walter E. St. Cla			59 GLOUC sition (Name of	ester Ave		CNTON, ML 20c. Location - Cit	
2	Pages nent of h ent: If ite		1 1 Surial 2 □ Cremation 3 □ F	Removal from State	metery, cren	natory or other pla	ce)			
-	rtmer rtent rtent	_	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidens			1 Cemete		-2005	Suitland	d, MD
<u>g</u>	permil. Pages Department of tell Importent: If its any injury or of		21. Signature of Fulleral Service Liberts				A SECURE	. D. 3	Or no	, MD 20736
			23a, Part1. Enter the disease, or complete	ications that caused the death			neral Hon no. such as cardiac	The second second second		Approximate
			23a. Part1. Enter the disease, or cont. I shock, or hear failure. List only of Immediate Cause (Final		2		,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a CENCERL Due to (or as a consequ		NO				Ime
	Examiner			Due to (or as a consequ	ence ory.					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
	cuted Id ransit	Examiner	Cause (Disease or injury that initiated events	c.						
ĵ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):					
, ,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rai director, page 2 should be detached for use as the burial-transit	licai		d						
5	ing p	Med	IF FEMALE:							
2	ath ca	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3□	Ectopic pregnanc	у		23d. Date o Month	f delivery Day Year
	the a	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5∟	Other (specify) _				,
Ĺ	ires that the death certificate signed by the attending phys d be detached for use as the		Part II. Other significant conditions con	ntributing to death but not resu	Iting in the ur	nderlying cause gr	ven in Part I.	23e. Did tob	pacçe use contribu	ite to the cause of death?
ה ס	uires sign ld be	d by						101	s 2 No 3	☐ Probably 4 ☐Unknown
3	rsician: The law require s certificate has been sig lirector, page 2 should b	Completed						24a. Was a	n 24h Wei	e autopsy findings available
ב ב	he lay s has ige 2	E D						autops	y prio neg! dea	r to completion of cause of th?
5	ifficate or, pa	e C	25. Was case referred to medical				26. Place of Deat			Yes 2 No
>	ding Physician: The Ih. h. After this certificate ha funeral director, page	0 B	avaminar?	fospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Ott	ner: 4 \(\text{Nursing Ho}			(Specify)
5	g Phy er thi	n: T	27. Manner of Death		28b. Time of	28c. Inju	ry at		ow injury occurred	Ороспу
2	ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day 16ar)	Injury		Yes 2 □No			
2	er de recto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, larm, str	eet, factory, office		28f. Location (St. City or Town		or Rural Route Number,
2	ital o rs aft al Di	Cer	/							
	Hosp 4 hou Funal	edical	(Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati	vledge, death on and/or inv	occurred at the til	me, date and place,	and due to the cared at the time, da	ause(s) and manne ate and place, and	ar as stated, due to the cause(s)
	To the Hospital or Attanding Pi within 24 hours alter death. To the Funaral Director: After the completely filled in by the tunera	Medi	one)	and manner stated.		29c. Licens				
	Wit To		29b. Signature and title of certifier	MA		23G. LIGHTS	N 11 C	1	9d. Date signed (A	8 7 120 5
			X COW I'L	world	00-1 7	110	8 11 0	/	1/141 1	0,000
1	D	11	30. Name and address of person who co	Transier cause of death (Item	23a) (Type,	CC MD	21701	STANIS	TILA	8,2005 Kras In
S	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrans Signati	ure			111.00	, 00,00	7
	Registr		ı APR 2 (2005 \ 1000	K	Angel !				

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 April 16, **Physician** Audrey Agnes Slingluff 11:02 A.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2825 Ivory Lane Port Republic Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days, Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Director 149-30-8634 64 Yrs. 1940 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28a-f show other traumatic event, the Modical Exporter must be notified at 1 ☐ Yes 💹 No Directo Maryland Calvert Port Republic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2825 Ivory Lane 20676 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23s any Injury or other traumatic event. The Medical Extending Const. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 ☐ Widowed ♣️X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Distributor Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elijah David Getty Ruth Shear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Strayer (Daughter) 2825 Ivory Lane, Port Republic, Maryland 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 4/18/2005 Alexandria, Virginia ' 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 21. Signature of Funeral Service Licensee Broomes Isl. Rd., Port Republic, Maryland 20676 24 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lune Cancer lyear /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the burial-transit certificate be executed and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, nding physicien an/Medical use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐ Pregnant at time of death Physici 5 Other (specify) ed by the e 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2×40 1 Tes 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tity 29d. Date signed (Month, Day, Year) April 18, 2005 cause of death (Item 23a) (Type, Print) Prince Freckrick, m 31. Date filed (Month, Day, Year) 32. Registres Signature State 2005 Registrar

1	_	For State Registrar
•		Registrar

State of Maryland / Department of Health and Mental Hygiene 0.5Certificate of Death

		Examir
	F	uneral irector
nd 21215-0036	e filed within 72 hours after death with the Maryland	other than "neturel", or tems 23a or 28e-f show vent, tre Madical Examiner must be notified at

	Physici	20	1, Decedent's Nam	ne (First, Middle, La	ist)							2. Date of D Month	Da		Year	3. Time of De	
	/Medic			Harold			r	1				April			005	12:34	рм
	Examir	ıer		(If not institution, given			•			Location		als M		,	of Death	rt	
			5. Social Security	t Memor	lal HO		L s. last birthday				24 Hrs.	CK, M	inth			place (State or Fo	oreian
	Funeral Director		199-24-		1 ∑ M 2□F	72		Months	Days	Hours	Min.	5/15/	193	32	Cou	PA	
	D .		Usual Residence	1		100 (City, Town or L	agation								Od. Inside City L	imite
	172 hours after death with the Maryland "neturel", or Items 23a or 28e-f show "Joal Examiner must be notitled at	'n	10a. State	10b. County		100.0	Dity, Town of L		. ,			1 X 1Yes					
	the N	Director	PA 10e. Street and No	Faye	ette			10f. Zip	Code	own			10g. C	tizen of \	What Cou	ntry?	
	3a or	0	2687 N	Morganto	wn Roa	d			15401					USA			
	death	Funerai	11. Marital Status	101941100	12. Was Dec	edent Ever in	U.S. 13.	Was Deced			rigin? (Spe	ecify Yes or N Rican, etc.)	0-	- 14. Race - American India Black, White, etc.			
92	or Ite	y Fu		ried 2 Married	1 XYes	2 🗆 No		1 ☐ Yes					i		v:Whi		
00	hours urel',	d by	3 Widowed	4 NDivorced 15. Decedent's E		ates: 195		dent's Usual Occupation				16b. Kind of Business/Indu					
15	in 72 " nel	olete		cify only highest gr	ade completed)	4.4	(Give	kind of wo DO NOT u	rk done d se retired	during mo: ()	st of worki	ing	100.1	and or b	G3111033/111	austry	
21215-0036	d within giene. er than "	Completed	Elementary/Sec.	undary (U-12)	College (Cus	tod	ian			Hea	alth Department			
	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiane. Item 27 Is marked other than "netun other treumatic event, Ite Macaical	Be		(First, Middle, Last						18. Moth	er's Name	(First, Middle	e, Maidei	n Suman	ne)		
Maryland		2		d Smithb Name/Relationship			10b Mail	ina Address	(Stroot			Marie al Route Numb	_			Code	
Mai	d 2 st th and t7 Is r treur			Smithbu		on							-			MD 20	679
re,	ges 1 and 3 of Health If Item 27 or other tr	L	20a. Method of Dis	sposition	_	20b.	Place of Disp	osition (Nar	ne of			Date			City or To		07
Ë				Cremation 3 D 5 Other (Speci		State	nesape				4/16	/2005	Be1	tsv	i11e	e, MD	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of E	uneral Service Lice	nsee							ymond-					
8	80 5 2 9		6	· Wir	in							irk, l		2075	4	Approximate	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final														en ith
	Physician /Medical		disease or conditi	Immediate Cause (Final disease or condition resulting in death) A. MYOCARDIAL INFARCTION. Due to (or as a consequence of): CORONARY - ARTERY DISEASE.													
	Examiner			- 1	C	3RONA	RY-	ARTO	RY	d	DISE	ASE					
	TIS TO	ner	Sequentially list of if any, leading to it	onditions, mmediate	b. Due to	(or as a conse	equence of):	A-AT	~		/	0511	2			-	
	acuted nd transi	ami	frany, leading to immediate cause. Inter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CABC HYPERTENSION RENAL Due to (or as a consequence of): INSO FFICIENCY CHF														
60,	be execian a		resulting in death)	Last	Due to	(or as a conse	equence of):	IEN	c4/	1	HE						
68760,	physics the l	dice		•	d				- /								
ox (eath certificate be executed attending physician and I for use as the burial-transit	cian/Medical	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, ou			75					74	23d. Dal	te of delive	ery	
m			in the past 1:	2 months?		ointh 2 □ Fe nant at time of		□Ectopic pr □ Other (sp						Мо	nth	Day Year	ſ
P.0	that the de led by the a detached t	Physi	9 Unknow							- in Dad		220 Did	tabassa		ributo to H	a cours of doot	h2
	uires tha signed d be del	by	Part II, Other sign	ificant conditions	INSUF	FIC 16	ENCY	inderlying c	ause give	en in Part	ſ.	1		_		ne cause of death ably 4 Unkr	
Sorc	w requir been s	etec		ANAE								24a. Was					
Records,	The law cate has page 2	Completed by										auto perfe	psy ormed?_		death?	psy findings avai impletion of cause	a of
Vital	en: Ti lificate or. pa	d)	25. Was case refe	erred to medical						26 Plac	e of Death	1 Yes	one)) 1	Yes	2 No	
Ĭ.	ysicien: is certific director,	To B	examiner?] No	Hospital	inpatient 2	☐ ER/Outpatie	nt 3 DC	Othe			me 5□Res		6 Oth	er (Specif	y)	
n of	ng Ph fter th ineral		27. Manner of Dea	th 5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		8c. Injun Worl	at c?	1	28d. Describe					
sio	tendi Jeath. tor: A the fu	cati	2 Accident	investigation 6 Could not be	19	ad Indiana - At	hama farm at	M		Yes 2		29f Location /	(Street a	ad Alumb	ar ar Dur	l Route Number,	
Division	after of Direction by	Certification:	4 🗌 Homicide	determined		ing, etc. (Spec	home, fam, st	reet, ractory	7, 011100		ľ	City or To	wn, State	e)	or or ridiz	r riodie rearriber,	
	spite hours merel y filled	aC	29a. Certifier	Certifying P	hysicien: To the	best of my ki	nowledge, dea	th occurred	at the tim	ne, date ar	nd place, a	and due to the	cause(s) and ma	inner as si	ated.	
	To the Hospitel or Attending Physicien: The law requires that the within 24 hours after death. To the Funerel Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detache	ledical	(Check only one)	2 Medical Exe		asis of examiner stated.	nation and/or ir				ath occurre	ed at the time,					
	Vith To t	Σ	29b. Signature an	title of certifier N. Men	doon	H	D	290		number	7/2	0		_		Day, Year)	
	_							24-17	20	UDSA	(70)	8.	102	1-1	~ >	,	
	3		Navanta	ara Mend	onca.	se or death (Ite	өт 23а) (Турө	PRI	NCE	FR	EDE	RICH	KI	77	106	78.	
	Sta	ite	31. Date filed (Mo		0 2005	Registrate Sign	nature K	A									
	Registr	101		711-11	. 0 (100)	Allen.	10 1 18	Mari	AND R								

		Please	Type or Prin					-		egible.		
		1 - For State Registrar	State of Ma	-	•	tment of F ificate of			giene Reg. No. 🤈	005	15000	
		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea		V	3. Time of Death	
Physici		Alfonso Maria	Tafur					Month APRIL	23 2	Year 2005	10:32 p. M	
/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)		4	4b. City, Town, o	r Location of Death	ALICALI		ounty of Death		
Exa, iiii	:	St. Mary's Hosp	ital			Leonar	rd t own		St	t. Mary	, † _S	
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign	
Director		354-68-9101	X M 2 F	84	Yrs.	Months Days	Hours Min.	(Month, Day May 29	1920	Colc	ombia	
9		Usual Residence of Decedent										
larylan show	_	10a. State 10b. County		10c. City, Towr	n or Loca	tion					10d. Inside City Limits	
Ba-f s	cto	Maryland St. M	ary's	Lexi	ngto	n Park					1 ☐ Yes 2 X No	
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	intry?	
23a	a	47112 Sorrel Dr	ive			20653			U.S.A.			
dea ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Wa	as Decedent of H	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri		
or It	F	1 Never Married 2 Married	1 Tes 2 No	D		XYes 2□ No	Specify:		80	pecify:	, 0.0.	
ural',	d by	3XXVidowed 4 □ Divorced	Year or Dates:				Colo	ombian	1 0,	His	panic	
tiled within 72 hours after death with the Maryland Hygiene. utter than "natural", or Items 23a or 28a-f show utter than "natural", or Items the notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	16a.	(Give kit	nt's Usual Occup	during most of work	ing	16b. Kind	of Business/Ir	ndustry	
nen hen hen	I du	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. DC) NOT use retired	3)					
led w lygie her t		12		I	Brewe	er	40 14-14-1-1-1-1	. /6" M. C.B.		wery		
be fit tal H d ot	Be	17. Father's Name (First, Middle, Last,					18. Mother's Name	•		татө)		
ould Men Marke Marke	ို	Fernando Tafur						Perdomo				
2 sh and Is m		19a. Informant's Name/Relationship (Гуре, Print)		_		and Number or Rura					
and ealth m 27			Son								and 20653	
of H of H if ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of cemeter	y, crema	ion (Name of tory or other plac	ce)	Date	20c. Locat	tion - City or T	own, State	
Pag ment ent:		* 4 ☐ Donation 5 ☐ Other (Specif		Brins	fiel	ld-Echol	s 4-26-	-2005	Charl	otte H	all, MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-4 show amy injury or other traumatic event, it a Medical Era-inermial be notified at ance.		21. Signature of Funeral Service Licer	1589	_	22. N	Name and Addre	ss of Facility Br	insfiel	d Fun	eral H	ome, P.A.	
977 2 2 9		Ellevill, Best	1 11100	1052	P.0). Box 2	79 Leonar	dtown,	mary1	and 20	650-0279	
		23a. Part1. Enter the disease, a com shock, or heart failure. List only	plications that caused tone cause on each line	the death. Do n	not enter	the mode of dyin	ig, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition										
/Medical		and the standard stan										
Examiner			Foot	Int	are	tion						
	jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	f):	1 - 0						
executed in and ial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Perip	nevat	Jarction Jarction Vascular Disease (a)							
exec n an ial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of	of):							
e be rsicia e bur	ca	(d Nype	V chole	u te	rolem	a					
eath certificate be ei attending physician for use as the buria	edical		11						- 7			
ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		۰.				23d	f. Date of deliv	rery	
death e atte d for	cia	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2 4□Pregnant at t			ctopic pregnancy Other <i>(specify)</i>				Month	Day Year	
The law requires that the death certificate be the base been signed by the attending physicis agge 2 should be detached for use as the but	Physician/M	9 Unknown	9 Unknown									
s that	by P	Part II. Other significant conditions of	ontributing to death but	t not resulting in	the unde	erlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to t	the cause of death?	
uires n sion		HTO			_			1 🗆 Y	′es 2□N	4o 3 ☐ Pro	bably 4 Hhknown	
w require been sig should t	ompleted	(AD						24a. Was a	20 2	Ah Wore aut	opsy findings available	
has ge 2	E D							autop	sy	prior to co death?	empletion of cause of	
	O							1 ☐ Yes		1 🗆 Yes	2 4 NO	
sician: The la certificate ha irector, page	Be	25. Was case referred to medical examiner?	Hospital:			oClock Oth	26. Place of Death				-	
	10	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury		tpatient ime of	3 DUA	4 U Nursing Ho				fy)	
ding Phy h. After this funeral o	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 4. Describe how injury oc Injury 4. Describe how injury 4.								Curred			
death. ctor: A / the fu	cat	2 Accident investigation 3 Suicide 6 Could not b	Α					OOL Logation (C	A A	lumbas as Du	al Barrio Alumbas	
or Attendated after death Director: in by the	Certification:	4 Homicide determined			ırn, s tree i	i, ractory, office		City or Tow		uniber of Hur	al Route Number,	
pital urs a arel C		00-0-4504	veide 7 7 1		4							
To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by 1	ledical	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exar	nysician: To the best of miner: On the basis of e	examination and	, death o d/or inves	ccurred at the tin stigation, in my o	ne, date and place, pinion, death occurr	and due to the d ed at the time, o	ause(s) and date and pla	d manner as s ace, and due t	stated. o the cause(s)	
thin the mple	Med	29b. Signature and title of certifier	and manner state	eg.		29c. Licens	e number	T.	29d Date e	igned (Month,	Day Year)	
7 ₹ 7 8		255. Signature and Street Miles	,)				7	_ '		-griou (month,		

State Registrar

30. Name and address of

MANOJ D PANWALA

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ALFONSO M TAFUR

31. Date filed (Month, Day, Year)

no completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

SHAH ASSOC CHARLOTTE HALL MD

29c. License number

0.5027

20622

			1 - For State Registrar		ryland / Dep <i>Ce</i>	artment of <i>rtificate o</i>		Mental Hy	/giene Reg. No. 20	05 15201
	Physic /Medi	cal	1. Decedent's Name (First, Middle, La	Tols	x0~			2. Date of De Month	rul 15 2	Year 3. Time of Death
	Examir Funeral	ner	4a. Facility Name (If not institution, giv Holy Cross Hospit 5. Social Security Number 6. S	:a1 Sex 7. Age	(In yrs. last birthday)	Silver If Under 1 Yea	r If Under 24 Hr	S. 8. Date of Bir		gomery 9. Birthplace (State or Foreign
	Director		223-46-0529 Usual Residence of Decedent 10a. State 10b. County	∑ M 2□F	67 Yrs.	Months Day	s Hours Mir	06-04-1		irginia
	the Maryle 28e-f shor	Director	D. C.		Washingt				10- Citions of Mall	10d. Inside City Limits 1 1 Yes 2 □ No
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is merked other then "natural", or items 23a or 28e-1 show or other traumatic event, the Modical Examinar must be notified at	by Funerai	2721 Hamlin Stree 11. Marital Status 1 🖾 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	t, N.E. 12. Was Decedent Edamed Forces? 1	0	200	18 Hispanic Origin? (ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	U · S · I 10g. Citizen of Wh U · S · I 14. Race- Black, Specify:	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other then "natur: vent, the M. cital I.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12) 12th	de completed) College (1-4or 5+	(Give	DO NOT use retir	e during most of wi	3		ness/Industry
aryland	2 should be fi and Mental F Is marked ot raumatic ever	To Be	17. Father's Name (First, Middle, Last) Fred L. Tol 19a. Informant's Name/Relationship (son	19b. Maili	ng Address (Stree	Helen H	lobb Webb	, Maiden Sumame) er, City or Town, St	ate Zin Code)
ore, Ma	es 1 and 2 and 2 of Health ar if item 27 is requered.		Althea D. Tolson/ 20a. Method of Disposition 1 Burial 2XCremation 3 D		Washi	lenia Sti Ington, I	ceet, S.E O.C.	Date	20c. Location - Ci	
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other 2000.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	()	Chesapeak	2. Name and Addr	ress of Facility W .	H. Bacon	Beltsvill Funeral D.C. 200	e, Maryland Home, Inc.
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or community shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) 5 a uantially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Aspiration Due to (or as a	he death. Do not ent on Pneumon consequence of):	er the mode of dy				Approximate Interval Between Onset and Death 5 days 8 days
8760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d.	consequence of):					
.O. Box 6	The law requires that the death certifics the has been signed by the attending ploage 2 should be detached for use as to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	sy		23d. Date o Month	f delivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of End Stage Renal		not resulting in the ur	nderlying cause gi	ven in Part I.			ite to the cause of death?
al Reco		Completed	Periphial Vascul	ar Disease				24a. Was a autop perfor		
Division of Vital Records,	Attending Physicien: The la redeath. r death. ector: After this certificate has by the funeral director, page 2	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo 27. Manner of Death 1 ☐ XNatural 5 ☐ Pending	Hospital: 1 XInpatient 28a. Date of Injury (Month, Day)	28b. Time of	t 3 DOA	her: 4 Nursing H	ath (Check only or dome 5 Resid 28d. Describe h	ne) lence 6 □Other (ow injury occurred	Specify)
Divisio	in the c	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		/ - At home, farm, stre	M 1]Yes 2□No	28f. Location (S City or Tow	itreet and Number o n, State)	r Rural Route Number,
	To the Hospitel or A within 24 hours after to the Funerel Direct completely filled in by	ledical	one)	vsician: To the best of a iner: On the basis of earth and manner state	xamination and/or inv	occurred at the ti	me, date and place opinion, death occu	and due to the curred at the time, d	ause(s) and manne date and place, and	or as stated. due to the cause(s)
0	Ton		29b. Signature and title of certifier	2	N. (1)	29c. Licens	45121		29d. Date signed (M	· ·
_	Star Begistr	te	Brian F. Reagan, 31. Date filed (Month, Day, Year) APP 9 0 200	MD Registrar's	th (Item 23a) (Type, F	1500 For	rest Glen			ing, Md. 20910

State of Maryland / Department of Health and Mental Hygiene) For Stata Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Jeanette 2. Date of Death H. Thompson Apr. 16, 2005 Year **Physician** 1:50p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville 4c. County of Death Examiner National Lutheran Home Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JaMonth Day 1915 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2X F 90 346-38-8816 Yrs. Wisconsin Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exal: in at mantice notified at once. Rockville Md. Montgomery Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 9701 - Ve 10f. Zio Code 20850 Veirs Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Legal Secretary School 18. Mother's Name (First, Middle, Maiden Surname) Hilma Carlson 17. Father's Name (First, Middle, Last) Be John Haugen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 9701 - Veirs Dr., Rockviile, Md. 20850 19a. Informant's Name/Relationship (Type, Print) Kristina Hughes-Executor Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Cemetery, crematory or other classe)
Metropolitan Crematory-4/28/05-Alexandria, Va. 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hysong Co., Inc.
6510-16th St., NW, Wash., DC 21. Signature of Funeral Service Licensee W.W. Approximate Interval Be ween Onset an Jeath 23a. Part1. Enter the disease o shock, or heart failure Lis Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy ō Month Day Year 4☐ Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO Certification: To this 28c. Injury at Work? After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Division 1 Natural 5 Pending in Hospins.
In 24 hours after death.
the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only onel To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 16,2005 res 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karesh- 9701-Veirs Dr., Rockville, Md. Dr.Charles W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 APR 2 0 Registra

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygione

				State of	Marylanu	•	cate of		Mental H	ygiene Reg. No.? () (76	15000		
			1. Decedent's Name (First, Mid-	die, Last)					2. Date of D	Peath	10	3. Time of Death		
	Physic		11171	TE		TO	YF		Month 1202	Day	Year	5-30 AM		
5	/Medi Exami		4a. Facility Name (If not instituti	on, give street and numb	er)			4b. City, Town, o	r Location of Dea	ath 4c. County	of Death	0 20111.		
*	Lxamii	ici	Manor Ca	re					aton					
	Funeral		5. Social Security Number	1	Age (In yrs. last		Under 1 Year	If Under 24 Hi			n.tgon			
	Director		577-30-9868	1□ M 2□XF	78	Yrs. Mo	onths Days	Hours Mi	n. (Month, L	1927 1927		lace (State or Foreign		
		1	Usual Residence of Decedent		70				mar. o	, 1927	was	sh., DC		
	/lanc		10a. State 10b. Count	у	10c. City, T	own or Location	n				10	Od. Inside City Limits		
	Men.	ğ	Maryland Prin	ce George's			Capito	l Heigh	ts			1 X Yes 2 □ No		
	oth with the Merylar 23e or 28e-f show ust be notified at	5	10e. Street and Number				of. Zip Code			10g. Citizen of W	hat Count	trv?		
	¥ S		012 B1	Davies				207/2				•		
	as 23	era	912 Booke		ent Ever in U.S.	13 Was	Decedent of H	20743	Spacify Vac or N	Unite	ed St - America			
_	within 72 hours effer deeth with the Meryland ane, than "netural", or items 23e or 28e-f show he Medical Examiner must be notified at	Funeral Director	1 ☐ Never Married 2 ☐ Ma	12. Was Decede	es?	If Yes	, specify Cuba	in, Mexican, Pue	Specify Yes or Norto Rican, etc.)	Black	, White, e			
21215-0020	rs ef		3 □ Widowed 4 □ Divorce	WV Chin	76. TAT 140	101	′es 2∏X No	Specify:		Specify:	В1	ack		
ş	hou tra	Completed by		nt's Education		l6a. Decedent's	Heusl Occur	ation		16b. Kind of Bus				
15	n 72	et	(Specify only high	est grade completed)		(Give kind	of work done of	during most of w	orking	160. Kind of Bus	SITIES S/ITIU	ustry		
12	than the	Ē	Elementary/Secondary (0-12)	College (1-4	or 5+)									
	e filed within al Hygiene. I other than "	ŏ	12th 17. Father's Name (First, Middle	l ast)			Secre		ame (First Middl	e. Maiden Surname	ernme	nt		
Maryland	should be find Mental ?	Be	7. 1. 2					10. 1410(116) 3 140			,			
Ŝ	1 Me	မ	Walter Pe	2.000						ttie Mae				
Pa	l 2 sho l end l is me		19a. Informant's Name/Relation							ber, City or Town, S				
	end lealth m 27		Richard E. T	oye, Jr		912 e of Disposition		r Dr., (Date	Heights,		20743		
Baltimore,	of H		20c. Location - 0	Location - City or Town, State										
Ξ.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Expected to the part of the										ind,	MD		
at	permit. Depertr Imports eny inje		21. Signature of Funeral Service Licensea 22. Name and Address of Facility Stewart Funeral Home											
Ω)	89 E 2 8	4001 Benning Rd., N.E. Wast										19		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cau	sed the death.	į.								
-	Physician		shock, or heart failure. Lis	t only one cause on eac	n line.			-		,		Approximate Interval Between Onset and Death		
J.	/Medical		Immediate Cause (Final		11-0	09	EA	-111	DIT		1			
	Examiner		disease or condition resulting in death)	a	HEH	K		ILU	RE					
		ē		00	2 1 4	a consequenc	e or):	2501	· D	TOFACE				
	uted I Insit	Aedical Examiner		■ b. CO		MY	, MK	I EK	V-	PSEUST				
	tificate be executed ig physician end es the bunel-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as	a consequenc	е от):				1			
68760,	sicia bur	a	Cause (Disease or injury	c										
88	icete phy s the	듛	resulting in death) Last		Due to (or as	a consequence	∍ or):							
	certif Iding Ise e	3		d										
Box	eath etter for u	Physician/N												
P.O.	he d r the ched	ysl	Part II. Other significant conditi	ons contributing to death	n but not resultin	g in the underly	ring cause give	en in Part I.	23b. Did	tobacco use cont	ribute to t	the cause of death?		
	thet the determination		HALLEN	STENS	TOP	1			1□	Yea 2□ No 3	3 Proba	ably 4 Unknown		
of Vital Records,	The law requires thet the death certificate be executed ate has been signed by the ettending physician end page 2 should be deteched for use as the bunel-transit	d by				V			040 11/4-1	T	24h War	o autonou findings		
Ö	requ	Completed	DIAL	SETES	, L	MEI	ITT	US	perf	s an autopsy ormed?	avai	e autopsy findings lable prior to apletion of cause		
ec	elaw hast je 2 s	ď	2 411 6								of de	eath?		
=		ပ္ပြဲ							10	Yes 2 Ne	1 🗆	Yes 2□ No		
/ita	Attending Physicien: The la in death. sctor: After this certificate has by the funeral director, pege 2	Be	25. Was case referred to medica examiner?	1			3,35	26. Place of De	ath (Check only	one)				
=	nis ce I dire	ို	1 ☐ Yes 2 ☐ No		atient 2 ER/	Outpatient 3	DOA Othe	er: 4El Nursing	Home 5□Res	idence 6 □Other	(Specify)			
0	ig Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of It	njury 28t Day Year)	b. Time of Injury	28c. Injury Work	at	28d. Describe	how injury occurred	d			
Ö	ath. r:Af	atic	2 ☐ Accident invest	igation		M		res 2 □ No						
Division	Atte	E E	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of	Injury - At home, etc. (Specify)	, farm, street, fa	ctory, office		28f. Location	(Street and Number wn, State)	or Rural i	Route Number,		
Ö	S effe	Certification:		ounding,	oto. (opouny)				Only or 10	m, oldio)				
	To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyli (Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	st of my knowled	dge, death occu	rred at the tim	e, date end plac	e, end due to the	cause(s) and man	ner as stat	ted.		
	To tha P within 24 To the F complete	Medical	Uney .	and mapmer	stated.									
	5 × 5 0	-	29b. Signature and title of certific	er .			29c. License	number		29d. Date signed	(Month, Da	ay, Yeer)		
			Shia	en U	Oans	1	1) (7389	221	APRIE	19	2005		
, /	(5)		30. Name end address of person	who completed cause	death (Item 23	a) (Type, Print)		1		D . A AT	2000	-111		
1			SHIVATU	60 SIN	= k	APSE	K KE	RMMN	YE	KOCHU	LLE	= YUU		
	Sta		31. Date filed (Month, Day, Year, APR 2 1 2	005 2. Regis	strar's Signature									
	Registr	ali'	PLD 4 1 4	UUJ AL.	Lo	-								

			1 - For State Registrar	State of I	Maryland / De	epartment of F Certificate of			giene leg. No.2 0 0 (5 15204		
	Physici		Decedent's Name (First, Min MARY	ddle, Last) ATLEE	THOMPSO	N		2. Date of Dea Month APRIL	19, Day 2005	3. Time of Death 5:17 P. M		
}	/Medio Examir		4a. Facility Name (If not institu	-		TAKOMA			4c. County of D	eath		
	Funeral Director		5. Social Security Number 051-09-7587 Usual Residence of Decedent	1 M 2 F	Age (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 5-30-0	9. VI	Birthplace (State or Foreign COUNTY) RGINIA		
	e Maryland 3a-f show ulffed at	ctor	10a. State 10b. Cou		10c. City, Town o					10d. Inside City Limits 1		
	3a or 2	I Dire	10e. Street and Number 3104 DOUGLAS	STREET, N.	Ε.	10f. Zip Code	0018			o. Citizen of What Country? U.S.A.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any highty or other traumatic event. It a Midfield Examinar must be notified at Once.	by Funeral Director	11. Marital Status 1 Never Married 2 N 3 XWidowed 4 Divorce	12. Was Decede Armed Force 1 Tyes 2	ont Ever in U.S. 967 17 No	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: BLACK		
Maryland 21215-0036	d within 72 ho giene, or than "natur ir e Mcdical I	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1) 11TH GRADE	dent's Education thest grade completed) College (1-4)	(C	ecedent's Usual Occup Sive kind of work done fe. DO NOT use retire BEAUTICIA	during most of work d)	sing	16b. Kind of Busine SELF EMP			
	uld be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Midd GARFIELD	ROBINSON			18. Mother's Nam	e (First, Middle, HALL	Maiden Sumame)			
Marj	id 2 sho lth and 27 Is ma trauma	6	19a. Informant's Name/Relation	onship <i>(Type, Print)</i> HODGES - NII		lailing Address (Street			-			
altimore,	ages 1 and out of Health it: If item 2, y or other i		20a. Method of Disposition	on 3 Removal from Sta	20b. Place of D cemetery,	isposition (Name of Corematory or other pla	CEM.	Date	20c. Location - City	or Town, State		
Balti	permit. Departm Departm Importer any inju		21. Signature of Funeral Serv		nekne		ss of Facility PI	NCKNEY-S	PANGLER F	UNERAL HOME		
	/Medical / Medical / Medic	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence of) as a consequence of)		y Arte	my Dis	st orst	Onset and Death		
O. Box 68	death certifi e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	I LIVE DITT	n 2 □ Fetal death t at time of death	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date of Month	delivery Day Year		
<u> </u>	The law requires that the ate has been signed by thrage 2 should be detache	by	Part II. Other significant cond	0 1 -	h but not resulting in th	ne underlying cause giv	ven in Part I.	23e. Did to	_/	e to the cause of death? Probably 4 □Unknown		
Vital Records,		Completed						24a. Was a autops perform 1 Yes	sv prior			
n of	ding Physiclen: Th h. After this certificate funeral director, pag	tion: To Be	25. Was case referred to med examiner? 1 Yes 2 No 27. Mann of Death 1 atural 5 Per	Hospital: 1 ☐ Inp	atient 2 ER/Outpa injury 28b. Tim Day Year) Inju	ie of 28c. Injury	ry at	ome 5 Reside	ne) ence 6 □Other (S ow injury occurred	Specify)		
Division	e Hospitel or Attending 24 hours after death. 9 Funerel Director: After etely filled in by the funer	ertification:	2 Accident INV 3 Suicide 6 Col 4 Homicide det	, street, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certi (Check only 2 Medicone)	fying Physician: To the be cal Examiner: On the basi and manner	s of examination and/o	leath occurred at the tile or investigation, in my o	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner late and place, and o	as stated. due to the cause(s)		
)	To the within 2 To the complet	Me	29b. Signature and title of cer	tifier Alt	andring mi	29c. Licens	14848	2	29d. Date signed (Mo	Catho		
2	(6)		30. Name and address of pres	son who completed cause	of death (Item 23a) (Ty 7600 Cov		311	Park in	D 209K			
	Sta Regist	ate rar	31. Date filed (Month, Day, Ye APR 2 1	ear) 2. Reg	istrar's Signature	out)						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Charles R. Taylor 15 2005 9:15 pm Apri] 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Long View Nursing Home Carroll Manchester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ M 2□ F Months Days Hours 218-12-3045 82 May 01 1922 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 StYes 2 □ No MD Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21102 USA 3332 Main Street 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married XYes 2 □ No fYes, Give 1 ☐ Yes 2XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Visual Information Specialist Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora B. Mosberg Albert R. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8405 Tachbrook Rd Baltimore, MD Cindy Johnson/granddaughter 4/19/2005 Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Daurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens Finksburg, MD 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. **Other algnificant** c**onditions** contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 XYes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 200 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 desidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

ဥ

Funeral

Director

the Maryland

parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Dapartment of Health and Mantal Hygiene. Important: if item 27 is merked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner inust be notified at once.

Baltimore, Maryland 21215-0020

Examine attending physician and for use as the bunal-transit ed by the datached signed be dat director,

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

40	1
.0	ı
ס	L
Ø.	ŧ
=	1
=	1
2	1
æ	1
7	⊢
.=	1
S	
\sim	
£	ı
₾.	ı
-	1
~	ı.
ਰ	
0	L
*	ı
	1
Δ.	ı
=	ı
≒	ı
Ÿ	
Q	
d)	г
~	

-
_
2

Certification

Medical

7	1
2	-
Sed Sed	
Ĕ	40.00
5	
a)	2

or Attending Physician: Irector: Aftar this n by the funeral o fillad in To the Hospital within 24 hours of To the Funeral Completely filled Hospital WJL 10 State

this

Aftar

death.

(Check only one) 29b. Signature and title of certifier

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

29a. Certifier

5 ☐ Pending

6 Could not be determined

investigation

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

address of person who con

em 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

2 □ No

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Pack Road Wistmins

a Am N 31. Date filed (Month, Day, Year)

MD 688 32. Regis

DHMH 16 Rev 6/95

Registrar

		1	For State	State of	f Marylar		partment o				giene Reg. No.	2005	15206			
			1. Decedent's Name (First, Middle, Last	")						2. Date of De	ath	Vess	3. Time of Death			
	Physicia	n	Constance C. Tur							Month April	Day 13	Year 200	5 3:00 PM			
1	/Medic Examin		4a. Facility Name (If not institution, give		nber)		4b. City, Tov	wn, or Location	on of Death	whrat		ounty of Dea				
	_xamm.	•	Genesis Eldercare	Spa C	reek Ce	enter	Anna	apolis			A	nne Ar	undel			
	Funeral		5. Social Security Number 6. Se	×	7. Age (In yrs 84	. last birthda		ear If Und		8. Date of Bir (Month, Da	y, Year)	9. Bir	thplace (State or Foreign ountry)			
	Director		214-05-2235	□M 2 X F	04	Yrs.				Oct. 11		20 M	aryland			
	pu *	-	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or	Location						10d. Inside City Limits			
	shor	5											1 ☐ Yes 2 🛣 No			
	Z8e-f	Director	Maryland Anne A	rundel			10f, Zip Co	napoli	LS		10g. Citize	en of What C	ountry?			
	death with the Maryland rms 23e or 28e-f show		2 Washington Cou	rt			2	1403			United States					
	ns 23	era	11. Marital Status	12. Was Dece	edent Ever in l	J.S. 13	3. Was Deceden If Yes, specify		Origin? (Sp	ecify Yes or No		4. Race - Am	erican Indian,			
36	be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "naturel; or Items 23e or 28e-f show orber then "naturel; or Items 23e or 28e-f show event. The Maulical Expressor count be callined at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 💢 No /e		If Yes, specify 1 ☐ Yes 2 🔀			Hican, etc.)		Black, Whi	white			
ş	thou sture	ed	15. Decedent's Ed			16a. De	cedent's Usual C	occupation	mant of word	in a	16b. Kin	d of Business	s/industry			
212	filed within 72 Hygiene. other then "nal ant, The Medic	Completed	(Specify only highest grades) Elementary/Secondary (0-12)	de completed) College (1	-4or 5+)	(Gi	ve kind of work of b. DO NOT use i	retired)	nost or work	ang						
212	filed withir Hygiene. other then ent, the M	mo	11				Seams	tress			Kite	Manu	facturing			
힏	othe othe	Bec	17. Father's Name (First, Middle, Last)							e (First, Middle		Sumame)				
<u>a</u>	ould be Mental karked o	10 E	Hassie Browning							ristens						
Maryland 21215-0036	2 should be and Mental is marked (19a. Informant's Name/Relationship (7				ailing Address (S									
Σ,	and 2 salth n 27		Robert G. Browni	ng / Ne			ashingto			napolis Date						
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from	State 20b.	cemetery, c	sposition (Name crematory or other	or ar place)	1			•	r Town, State			
Ē	ment ment: lent: jury		4 □ Donation 5 □ Other (Specify	<i>'</i>)	Ва	1timo	re Crema				2005 Baltimore, Maryland n M. Taylor Funeral Home, Inc.					
Baltimore,	permit, Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked, any injury or other traumatic ev	d a	21. Signature of Funetral Septile Liben				is, MD 21401									
	g 5		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that o	aused the dea	ath. Do not	enter the mode o	of dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between			
	Physician	g) 18	Immediate Cause (Final disease or condition		Cor	ehn	os ale	- a	Here	al o	celu	1100	Onset and Death			
	/Medical		resulting in death)	Due to	(or as a conse				100							
	Examiner		Sequentially list conditions,	b												
	p #	iner	if any, leading to immediate aud. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	equence of):										
	cate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conse	equence of):										
8760,	be ex ician burial	ai Ei			(*: **											
87	physic the	dicai		. d												
9 X	certifi iding	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of preg						2:	3d. Date of de	elivery			
Вох	The law requires that the death certific the has been signed by the attending to page 2 should be detached for use as	Physician/Me	in the past 12 months?		oirth 2 □ Fe nant at time of		3 ☐Ectopic preg 5 ☐ Other (spec					Month	Day Year			
o.	the d y the	ysi	1 ☐ Yes 2 ☐ Good 1 ☐ Yes 2 ☐ Unknown	9□ Unkn	own											
<u>α</u>	res that igned b be deta	by Pi	Part II. Other significant conditions of	ontributing to d	eath but not re	sulting in th	e underlying cau	se given in P	art I.	23e. Did	tobacco us	se contribute	to the cause of death?			
rds	quires n sign	d D								1 🗆	Yes 2	> 4% 3□F	Probably 4 Unknown			
Records,	w requir s been si should	jete								24a. Was		24b. Were a	autopsy findings available completion of cause of			
Re	The law ate has page 2 t	Completed								perf 1 ☐ Yes	ormed?	death? 1 ☐ Ye	,			
Vital	(0)	a)	25. Was case referred to medical					26. P	lace of Dea	th (Check only	one)					
	di S	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆	Inpatient 2	☐ ER/Outpa	itient 3 DOA	Cther:	Nursing H	ome 5 🗆 Res			ecify)			
u of	ding Phy n. After thi funeral		27. Manner of Death THatural 5 Pending	28a. Date (Mor	of Injury hth, Day Year)	28b. Tim Inju		: Injury at Work?		28d. Describe	how injury	occurred				
Sio	Attending r death. ector: After by the fune	atle	2 Accident investigation	1			М	1 Tes	2 □ No		/ *					
Division	l or Attendate after death	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	200. Flac	e of Injury - At ling, etc. <i>(Spe</i>	home, farm, cify)	, street, factory, o	office			(Street and wn, State)		Rural Route Number,			
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier Certifying Pt	veicion: To 4h	a hast of my !-	nowledge 4	eath occurred of	the time dat	e and place	and due to the	cause(s)	and manner :	as stated.			
	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Technique Pr (Check only 2 Medical Exar	niner: On the b	e best of my k basis of exami aner stated.	nation and/o	r investigation, in	n my opinion,	death occu	rred at the time	, date and	place, and du	ue to the cause(s)			
	o the ithin o the omple	Mec	29b. Signature and title of certifier	1)	712-1941		29c. l	License numl	ber		29d. Date	signed (Moi	nth, Day, Year)			
	F ≯ F ŏ		1	Varin	m	>		(1) 3	1621	2	4	1/4/2	1001			
			30. Name and address of person who	mpleted cau	se of death (It	em 23a) (Ty	pe, Print)		.^	. N		A 4 1	21619			
			60 J	Savit	se.	2102	0,0	anh	· VIVI	ve cl	ال ل	r. ord	21619			
	St	ate	31. Date filed (Month, Day, Year)		Redistrar's Sig	nature	1 00									
	Regist	rar	APR 19	2005	TO BOOK	A	63342	/								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Apr 8560 51ma 2005 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Kas Spring Mont EN 2128 Silver SOMER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2□,F 220-51-4646 Sept. 20 1952 Iran Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits laryland 10e. Street and 2128 Fd Silver Springs Montgomery XIX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2128 Edgewater Parkway 20903 Iran 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married XX Married ☐ Yes X No Yes, Give 1 ☐ Yes 2 V No Specify: ^{Specif}€aucasaian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physician Ophthamologist Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mohsen Azimzadeh Tabrizi Ashraf Zeinolabedini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2128 Edgewater Parkway Silver Springs, MD Syamack Ganjavian - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stonewall Memory Gardens April 26,05 Manassas, VA 22. Name and Address of Facility Loudoun Funeral Chapel, Inc. 21. Signature of Funeral Service Licenses 158 Catoctin Circle Leesburg, VA 20177-1316 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Tes 2 No 25 ☐Other (Specify) 27

Examiner or Attending Physician: The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, I Director: A within 24 hours e To the Funeral I completely filled Hospital

Physician

/Medical

Examiner

Funeral

Director

al', or Items 23a or 28a-f show Examiner must be notified at

t: If Item 27 I.

Injury

Physician /Medical

5

Funerai

\$

Completed

Be

Examine

Physiclan/Medical

ð

Completed

Be

Medical Certification:

with the Maryland

Pages 1 end 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0020

		24a. Was an autopsy performed? 24b. Were autopsy fir available prior to completion of ca of death?
25. Was case referred to medical examiner?	26. Place of Deat	n (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence 6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) P 75 200 A M 28c. Injury at Work? 1 □ Yes 2 No	28d. Describe how injury occurred Soicide by hanging
3⊠Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Numb City or Town, State) 2 1 2 5 Edge where
29a. Certifier (Check only one) 1 CertifyIng Ph	ysiclan: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	and due to the cause(s) and panner as stated.

29b. ignature and title of certifie 29c. License number D00428 29d. Date signed (Month, Day, Year) 25 2005

Route Number, PK

IN WO DWE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \geq 10 f merca

BRECHER MD DME Silver

State Registrar 31. Date filed (Month, Day, Year) MAY 0 2 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year GLENN MAHLON 12:20p^M TURNER APRIL 2005 /Medical 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 24469 Porters Grove Rd. Chestertown Kent | Months | Days | Hours | Min. | Aug 18 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1923 Pennsylvania 1)XDM 2□F 81 Director 186-16-1661 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location if item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Kent Chestertown Director MD 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 24469 Porters Grove Rd. 21620 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No 1943 If Yes, Give Year or Dates: —1946 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White δ 3 ₩ Widowed 4 Divorced -1946Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "n any injury or other traumatic event, the Media once. Commercia1 Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard L. Turner Flora Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn R. Turner (son) 10636 Worton Rd. Worton, MD. 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation Kent Cremation 4-27-05 Smyrna, DE. 21. Signature of Funeral Service Clonce Galena Funeral Home of Stephen 118 West Cross St. Galena, MD. L. Schaech 21635 M00510 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** BLADDER MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and shed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has autopsy 2 No 1 Yes Hospitel or Attending Physicien: 4 hours after death. filled in by the funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home SEResidence 6 Other (Specify) 1 Yes 25 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tr James E. Lacey, 516 Washington Ave. Chestertown MD. 21620 M.D. 31. Date filed (Month, Day, Year) legistrar's Signature State MAY 0 2 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Parker P. Vito а м April 18, 2005 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Montgomery 8. Date of Birth (Month, Day, Yea April 25, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) Months 1**∑** M 2□ F 1916 Washington, DC Director 578-01-5568 Yre 88 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumsite event, the Madical Examinar most be notified at Director 1 ☐ Yes X☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 308 Ladson Road 20901 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hyglene.
Is marked other than "natural", or ite. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominic Vito Elena Fiorita 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health ar Dolores A. Carr/ Daughter 6656 Seagull Court, Frederick, Maryland 21703 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 20, 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or oti 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 I. be a 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Atherosclerotic Heart Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 2 No Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA his 28a. Date of Injury (Month, Day Year) Hospital or Attending PI 24 hours after death. Funeral Director: After the 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059373 April 18, 2005 to son 17+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dawn Marie Christerson, M.D. 10301 Georgia Avenue, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signature State nacks) APR 2 0 2005 Registrar

		_	1 - For State Registra AMEND#19aperFH				artment <i>tificate</i>				Reg. N	20	05	152	210	
	Physici		1. Decedent's Name (First, Middle, Las Russel H. V	") Nhite						2. Date Mont Apri			ear	Time of De		
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, To	own, or Loc	cation of De			4c. County of Death				
			Holy Cross Hospi	.tal			Sil	ver S	Spring	g		Montg	omery			
	Funeral Director		5. Social Security Number 6. Security Number 198–48–7236 Usual Residence of Decedent	9x 7. Age □ M 2 🕅 F	9 2	ast birthday) Yrs.	If Under 1 Months I		Under 24 H lours M	lin. (Mon	of Birth th, Day, Yea 25,	1912 9.	Birthplace (Country) Virgin	State or F	oreign	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. In	side City	Limits	
	Mary I sh	ţo	D.C. N/A		Wa	shing	ton						K	∏Yes 2	□ No	
	r 28g	lrec	10e. Street and Number				10f. Zip C	ode			10g. (Citizen of Wha	it Country?	_		
	ath with the Marylan 23a or 28a-1 show ust be notified at	a D	1312 Juniper Stre	et, N.W.			2	0012			Un	ited S	tates			
920	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or Items 23a or 28a-f show avent, the Medical Examinar must be matified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ XV If Yes, Give Year or Dates:		= 1	Was Deceder f Yes, specifi 1 ☐ Yes 2		nic Origin? Mexican, Pu Specify:	? (Specify Yes uerto Rican, et	or No- c.)		American Ind White, etc. Black	dian,		
21215-0036	nin 72 ho n "natur Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			16a. Deced (Give life.	cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired)			16b.	16b. Kind of Business/Industry					
21,	filed within Hygiene. other then "	E O	Listing it any occordary (0°12)	College (1-401 5	17)	Hom	emaker				0	wn Home	e			
ng	be filed tal Hygid d othar avant, t	Be (17. Father's Name (First, Middle, Last)					18	. Mother's I	Name (First, M	fiddle, Maid	en Sumame)				
<u>y</u>	D 9 2 0	ဥ	Ellis Gaines							ie Byrd						
Maryland	an a		19a. Informant's Name/Relationship (1 Hayden Ida Haynos/ Daugh	уре, Print) nt or						r Rural Route I						
di.	s 1 and 2 if Health Item 27 other tra		20a. Method of Disposition		20b. Pl	ace of Dispo	sition /Name	ne of Date			_	Ington, D.C. 20012 20c. Location - City or Town, State				
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		1 Burial 2 □ Cremation 3 ☐ 4 □ Donation 5 □ Other (Specify		Ne	metery crer W M C	ZIOn	Bapt.	• /	4/22/05		lkerto				
Ħ	ortan		21. Signature of Funeral Service Licen		Cr	nurch	Cemete Name and	ry Address o	7	Service		INCICO	115 VII			
ä	Depar Impor any In		Soanna E.	cliberr	1_	7	cGuire 400 Ge	orgia	eral a	N.W.	: Wash	ington	. D.C.	20	012	
			23a. Pag1. Enter the disease, or comp shock, or heart failure. List only	blications that caused	the death							Ing con	Appr	roximate val Betwe		
	Pnysician		Immediate Cause (Final disease or condition	Pneum										et and Dea		
	/Medical Examiner		resulting in death)	Due to (or as		ience of):										
	Examiner	L	Sequentially list conditions,	b												
	led isit	nlner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequ	ience or):										
	al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as a	a consequ	ience of):										
8760,	ate be executed hysician and the burial-transit			d.												
Ö	tificate g phys as the	ledic														
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ XNo 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic prec Other (spec					23d. Date o Month	f delivery Day	Yea	ar	
<u>α</u>	res that I signed by be deta		Part II. Other significant conditions c	ontributing to death be	ut not resu	ılting in the u	nderlying cau	use given is	n Part I.	23e	Did tobacc	o use contribu	ite to the cau	se of dea	th?	
rds	quires n sign	d by	Hypertension, U	inary Tra	ct Ir	nfecti	on, De	hydra	ation	_	1 🗌 Yes	2 □ No 3[_ Probably	4XXJnk	known	
00	The law requires that the tee bas signed by the bas been signed by the bage 2 should be detache	plete								24a.	Was an	24b. Wer	re autopsy fij	ndings ava	ailable	
Vital Records,	The la	Completed								_	autopsy performed Yes 2 X	? dea	r to completi th? Yes 2X1	on of caus	36 OI	
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26	3. Place of I	Death (Check				-		
of V	Physician: this certific ral director.	P	1 ☐ Yes 2 XNo	Hospital: 1 X Inpatie		ER/Outpatier	-			ng Home 5 □			(Specify)			
'n	ding P. h. After funera	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury		c. Injury at Work?		28d. Des	cribe how in	jury occurred				
Division	r Attending I er death. ractor: Atter by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be		urv - At ho	me, farm, str	M factory		2 □ No	28f Loca	tion /Street	and Number of	or Rum I Rou	to Numbo		
Ο̈́	lor A after Dirac	ertif	4 Homicide determined	building, etc	c. (Specify	<i>')</i>	eet, lactory,	omce			or Town, St		or murai mou	te rvumbe	,	
	To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	edical C	29a. Certifier 1 X Certifying Ph (Check only one)	ysician: To the best on the basis of and manner sta	examinat	wledge, deat ion and/or in	n occurred at vestigation, in	t the time, on my opinion	date and pl on, death o	lace, and due to accurred at the	time, date a	n(s) and manne and place, and	er as stated. I due to the c	cause(s)		
	To th within Fo th compl	Me	29b. Signature and title of certifier	/			29c.	License nu	ımber		29d. I	Date signed (A	Month, Day,	Year)		
			> Turnoya				D3	2332			Ap	ril 20,	2005			
	5	-	30. Name and address of person who	completed cause of d	eath (Item	23а) (Туре,	Print)						-			
		-	Suresh K. Gupta					#220,	, Silv	ver Spr	ing,	MD 209	902			
:	Sta Regist		31. Date filed (Month, Day, Year) APR 2 0 20	32 Registra	ar's Signat	ure for	will									

		State of Maryland / Department of Health at Certificate of Death	nd Mental Hygi	iene				
		1. Decedent's Name (First, Middle, Last)	2. Date of Death	g. No.	05 1521			
	sician	Levie Opel Wilkerson	Month /	' 9 89 -	Year 1 1 Meath			
	edical miner	4a Facility Name [Iffnot institution give street and number] / 4b. City, Town	h, or Location of Death	4c. County	Of Death			
EXAI	iiiiei	bers Hend Hospital Porter Sc	alishuru	1/1/	COMICA			
Funer	ral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	4 Hrs. 8. Date of Birth Min. (Month, Day,	Vaarl	9. Birthplace (State or Foreign			
Direct	or	214-28-1388 1 M 2 F 76 Yrs. Months Days Hours	8/12/19	28	Vorth Carolina			
and w		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
Maryli 4 sho	ō	Maryland Wicomico Salisbury	1⊠ Yes 2□No					
28a	5	10e. Street and Number 10f. Zip Code	10	10g. Citizen of What C				
death with the Maryland ms 23a or 28a-f show	Funeral Director	351 Deers Head Hospital Road 21801		USA	, .			
deat deat	ner	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origi Armed Forces? 13. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	n? (Specify Yes or No-	14. Race	- American Indian,			
after or ite	豆	1 Never Married 2 Married 1 Yes 2 No H Yes Give 1 Yes 2 No Specific	ruerto rican, etc.)		c, White, etc.			
of ZIZI3-00Z filed within 72 hours Hygiene. ther than "natural", ent, the Wedical Exa	d by	3 № Widowed 4 □ Divorced Year or Dates:		Specify:	white			
n 72 n	Completed	15. Decedent's Education (Specify only highest grade completed) [Specify only highest grade completed) [Specify only highest grade completed] [Me. DO NOT use retired]	of working	16b. Kind of Bu	siness/Industry			
with iene.	E E	Elementary/Secondary (0-12) College (1-4or 5+) Housewife		Domest	tic			
offied of Hyg	Be	17. Father's Name (First, Middle, Last) 18. Mother	s Name (First, Middle, M					
aryidari should be nd Mentel marked c	To B	Charles Harison Pruitt Bu	lah Luffman					
2 sho end h is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Number,	City or Town,	State, Zip Code)			
e, IV		Patricia O. Smith/daughter 5585 E. Nithsdale D	r., Salisbu	ry, MD	21801			
Pages 1 nent of H nnt: if iten		20a. Method of Disposition 1XI Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)			City or Town, State			
Daltilli Nemit. Par Separtmen mportant: Iny injury		4 Donation 5 Other (Specify) Parsons Cemetery	4/23/05	Salisbu	ry, MD			
Defilition 9, Intelligence of	once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funera	l Home Prof	essiona	l Association			
		Markey (5)0 501 Snow Hill R	d., Salisbu	ry, MD	21804			
Disconinte		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respiratory arre	st,	Approximate Interval Between Onset and Death			
Physicia / /Medica		Immediate Cause (Final disease or condition resulting in death) a. Arterio Sclerothic Curdio Vasc	o. be di	Canca	1			
Examine	er	disease or condition resulting in death) a. HITEIOSCETOTIC CUTOLOVICO Due to (or as a consequence of):	May Car	stuse	seral years			
D #	ne	Charin regal tailure			Severa			
oof ou, icete be executed physician end s the burial-trensit	Examiner	Sequentially list conditions, Due to (or as a consequence of):			Diversi			
be ext	Cai E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			years			
	얼	that initiated events resulting in death) Last Due to (or as a consequence of):			1			
certif nding use a	Z	d		AA	1			
death death death	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22h Did tol	hacco use con	tribute to the cause of death?			
trate by the deche che	J. J.	and the second s	1 □ Ye	1/	3 Probably 4 Unknown			
s tha gned be de	ğ			7,111				
v requires to been signed should be	ted		24a. Was an	autopsy ned?	24b. Were autopsy findings available prior to			
law ras b	Completed				completion of cause of death?			
The The	ပ်		1 □ Ye:	s 210 No	1 ☐ Yes 2 ☐ No			
iclen Sertifi ector	Be	examiner? /	f Death (Check only one					
Phys C	1. 10	1 inpatient 2 inpatient 3 in DOA 4/2 Nurs	ing Home 5 Resider					
ding 4	ţ	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No		w injury occurre	o .			
r Attending ter deeth. rector: After	E Ca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Str	eet and Numbe	r or Rural Route Number,			
s effe	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town,	City or Town, State)				
To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours elected eath. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funerel director, page 2 should be deteched for use a	edical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	place, and due to the car occurred at the time, da	use(s) and man	ner as stated.			
ithin 2 of the	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number			(Month, Day, Year)			
8 4 8 4	7	Doolby MD Doolby	003	21//	9/0			
2,	3	30. Name and autoress of person who completed cause of death (tem 23a) (Type, Print)		7//	1103			
170	J	Tain J. Hunna M.D. PO Box 2018 Solishiai	MD 218	102-X	2018			
U,	,	1143. 11600 11. 11. 11. 11. 11. 11. 11. 11. 11. 1		- 1	0/0			
	State istrar	31. Date filed (Month, Day, Year) APR 2 1 2005 32. Egistrar's Signature			.078			

			1 - For State Registrar	State of M	aryland	-	artmen rtificate			and M	ental Hy	giene	10	75	150	10
	Physicia /Medic		1. Decedent's Name (First, Middle, Li	ANN	WOO	LF					2. Date of D Month	eath Day	4	Year 05	3. Time of 0	P M
	Examin Funeral		, , , , , , , , , , , , , , , , , , , ,	y Memo	y(ally		4b. City, If Under Months	ale	Location of	rd	8. Date of Bi	irth	1	of Death	tt- lace (State or	Foreign
death with the Maryland	Director	_	Usual Residence of Decedent 10a. State 10b. County		56						Jan 2	, 194	9	Penn	Sylvan: Od. Inside City	ia Limits
	with the M a or 28a-f be notifie	Director	MD Garrett 10e. Street and Number		Fr	1ends	10f. Zip	Code				10g. Citi	1 ☐ Yes 2 📆 No			
	ours after rai', or ite Examina	d by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give							0-	USA 14. Race - American Indian, Black, White, etc. Specify: White					
1212-	within 72 ene. than "nai	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12 th	Education rade completed) College (1-4or		(Give life.	dent's Usua kind of wor DO NOT us	k done di e retired)	uning most	of working	ng			usiness/Inc		
Imore, Maryland Z Pages 1 and 2 should be filed	ould be filed Mental Hyg arked othe atic event,	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's N						aldin	e M. F	Own Home st, Middle, Maiden Surname) M. Ryan					
	2 4 4 4		19a. Informant's Name/Relationship Dr. Michael A. Wo 20a. Method of Disposition		d	582	Milto	n Fr	iend	Rd.,	Frier	ndsvi	lle,		21531	
	Page ment o ent: if ury or		1 Bunal 2 Cremation 3 4 Donation 5 Other (Special Signature) of Fune√al Service Lies	ify)	9	eel (sition (Name natory or of Cemete Name and	ery	Apr.	28,		Fri	end.	svill	e, MD	
ñ	permit. Departition of the permit. Departition of the permit of the perm		23a. Part1. Enter the disease, or con shock, or heart failure. List only	Pluma,	ed the death.	Do not ent	79 Mi	ller of dying	St.,	Gra cardiac or	ntsvil	le, i	MD_	2153	Approximate	
8/60,	death certificate be executed E x x and mail transit and tor use as the burial-transit and to the transit and to the transit and to the transit and transit a	dicai Examiner	Immediate Cauba (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequent	nce of):	rca	· / (^	nave	7 09	isade	uro	lise	e 4e	Onset and D	
O. Box 62	at the death certifica by the attending ph nached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 Fetel de at time of deat	ath 3	Ectopic pre					2	23d. Date of delivery Month Day Year			ar
cords, P.	signed d be de	þ	Part II. Other significant conditions	contributing to death	but not resultir	ng in the u	nderlying ca	use giver	n in Part I.		23e. Did	robacco use contribute to the cause of death? Yes 22 No 3 Probably 4 Unknown				
итаі жесс	The law ate has b page 2 s	Completed								24a. Was auto perfe 1 \(\text{Yes} \)		prior to completion of cause of death?			railable ise of	
	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	tient 2	/Outpatien	it 3□ DO/	0			(Check only		. □Othe	er (Specify)	
lon of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation							ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred						
DIVISION	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in by	Certification:									wn, State)				er,	
	Fo the Hosi within 24 ho Fo the Fund completely fi	Medical	29a. Certifier (Check only one) 1☐ Certifying P 2☐ Medical Exa 29b. Signature and title of certifier	hysician: To the best miner: On the basis and manner s	of examination	dge, death and/or in	vestigation,	t the time in my opi	nion, death	d place, ar h occurre	nd due to the d at the time,	date and	place, a	nner as sta and due to I (Month, E	the cause(s)	
	F ≯ F 8		30. Name and address of person who	melleted cause of	Roath (Item 23	Sa) (Tune	1	12	619	54		4	/2	.4	105	
	Sta	te	P. Danie MI 31. Date filed (Month, Day, Year)	lev Do	trar's Signature	olt	Ac	res	· Dr	0	axte	ind	\ V	ND	كال	0
	Registr		APR 2 6	2005	A	8 1	and a									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First Middle Last) 3. Time of Death Day **Physician** Month Year JAMES 25 HOWARD WEBB 2005 APRIL 1:40p/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Oct 5 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F 217-42-5526 1943 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28e-f show the Medical Exertitives has be notified at Director 1 ☐ Yes 2 ☑ No Queen Anne's Chestertown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Round Top Rd. 21620 U.S.A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filad within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ۵ 3 Widowed 4 Divorced 'natural' Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Branch Manager 12 Banking permit. Pagas 1 and 2 should be fills Department of Health and Mental Hy Importent: If item 27 Is marked othe eny injury or other traumatic event, 90ccs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse A. Webb Etta Skeggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (sister) 1104 Round Top Rd. Chestertown, MD. 21620 Mary Marvel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Still Pond Cem. 4/29/05 Still Pond, MD. ' 4 ☐ Donation 5 ☐ Other (Specify), 21. Signature of Full er of Service in ons 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Immediate Cause Final Physician disease or condition resulting in death) CARDIO Pulmonary ARROST /Medical Due to (or as a consequence of): Examiner Brondingen CARCINONO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exar iner use as the burial-transit The law requires that the death certificate be exacu Due to (or as a consequence of): Box 68760, nding physiclan Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Di sease certificate OBSTRUCTIVE PULMONANZ 1 ☐ Yes 2 3 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) 223 High St. Chestertown, MD. 21620 John C. Arrabal, M.D. 32. Registrar's Signature State Registrar

		i icasc	State of Man				•	iene	
		For State Registrar	State of Mary		tificate of L			eg. No. 2 11 11	15011
		Decedent's Name (First, Middle, Li	ast)				2. Date of Dea	time has been	3. Time of Death
Physic /Med		Bernice R. We	inhild				April	25 200	5 3. PM
Exami		4a. Facility Name (If not institution, gi	\ \	\	46. City Town, or	Location of Death	'	4c. County of Dea	
Funeral		5. Social Security Number 6.	Sex 7 Age (I	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Batting 9. Bi	tholece (State or Foreign country)
Director		575-22-6504	1□M 280 F	79 Yrs.	Months Days	Hours Min.	(Month, Day 9-30-1	925 H	AWAII
and		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town or Lo	cation				10d. Inside City Limits
Mary F-f sh	tor	MD Harfo	rd	White H	all				1 ☐ Yes 2X No
ith the or 28s	Oirec	10e. Street and Number	1 7 3		10f. Zip Code			0g. Citizen of What C	Country?
a 23a	erail	2817 Hitchco	12. Was Decedent Eve	or in ILC 12	2116			U.S.A.	ooigan ladiaa
ritter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🔀 No		Was Decedent of Hi f Yes, specify Cuba		Rican, etc.)	Black, Wh	
IIIU Z I Z I 3-0030 be filed within 72 hours atter death with the Maryland tal Hyglene. d other than "natural", or frama 23e or 28a-f show event, it e Moulcal Examinar must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify: W	nite
n 72 h	Completed	15. Decedent's I (Specify only highest g		16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of won	king	16b. Kind of Busines:	s/Industry
d withi	omo	Elementary/Secondary (0-12)	Cottege (1-4or 5+)	1	omemaker			Own Ho	me
id be file ental Hyg ked othe	Be	17. Father's Name (First, Middle, Las				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
should I	2	Manuel Britte		10h Maili	- Address (Chroste	Rose A		C/4 T C4-4-	7: 0-1:1
INIGIT		19a. Informant's Name/Relationship George D. We:			_			r, City or Town, State, ce Hall, MD	
IC, IV		20a. Method of Disposition		20h Place of Disno	sition (Name of		Date	20c. Location - City o	
DEJILIMOTE, INSTYISTIO ATATO-COOD permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene Important: If them 27 is marked other than "natural", or itama 23s or 28s-f show eny injury or other traumatic event, the Moultal Examinat must be notified at once.		1 XBurial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec	(A)	St. Joh Baptist	natory or other place in the Cemeter	y 200	il 28,	New Free	•
Dall permit. Departi Import		21. Signature of Superal Service Lice	ahsofe "	2	2. Name and Address	ss of Facility J.	J. Hart	enstein Mo edom, PA 1	rtuary, Inc.
		23a. Party. Enter the disease, or co	mplications that caused th	evil				<u>.</u>	Approximate Interval Between
Physician		Immediate Cause (Final	y one cause on each line.	DSCLER					Interval Between Onset and Death
/Medica	1	disease or condition resulting in death)	a. Due to (or as a c		ere o	2 100 1310	viisa	HITT BI	(EII)C
Examine		Sequentially list conditions,	b	0					
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence or):					
5U, be executed icien and burial-transit		that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
	lical	•	d						
X 68/ certificate nding phys	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy				22d Date of d	
death cer death cer e attendir	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 { 4□Pregnant at tirr	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
at the diby the etached	hys	9 Unknown	9□ Unknown						
	by	Part II. Other significant conditions	contributing to death but i	not resulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Dinknown
	eted						-		
The law	Completed						24a. Was a autop perfor	sy prior to death?	
VITAL HEC sician: The law certificate has b irector, page 2 s	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or	2√2No 1 □ Ye	es 200/No
Of Vital Physician: r this certifica	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Othe	or /		ence 6 □Other (Sp	ecify)
ISION C Itending P death. stor: After t the funera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Worl	yat k? Yes 2 □No	28d. Describe h	ow injury occurred	
	fical	2 Accident investigat 3 Suicide 6 Could not	be 28e. Place of Injury	- At home, farm, st		163 2 110		treet and Number or F	Rural Route Number,
DIN tal or s after al Dire	Certification:	4 Homicide	building, etc. ((Specify)			City or Tow	n, State)	
DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b;		(Check only 2 Medical Ex	Physician: To the best of a miner: On the basis of each	xamination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the o	ause(s) and manner a	as stated.
o the or the or the or the or the or the	Medical	29b. Signature and title of certifier	and manner state	id.	29c. License			29d. Date signed (Mor	
-3-5		Jesue	10,00	00~	Di	28195		4/25/05	17
		30. Name and address of person w	o completed cause of dea	ith (Item 23a) (Type	Print	11	n	10	
4		JASNESM (31. Date filed (Month, Day, Year)	AKITANI, 32. Registrar's	7220 s Signature	1ARK	HEIGH	D HYE	BALLO	MI) 21208
Regis	itate strar	MAY 0 2	2005	H A	and a				
DHMH 17 Rev 1	/2001		- Julian	1					
				ORIGIN	IAL				

		For State Registrar	State of Maryland	Certific	cate of L	Death	2. Date of Death	g. No.	13 5
Physicia	ın	1. Decedent's Name (First, Middle, La	Wills				Month	Day	3. Time of De. 05 8:05
/Medic Examin		4a. Facility Name (If not institution, given Harbor Hospit		4b.		Location of Death imore		4c. County o	
Funeral Director		219-48-1055	Sex 7. Age (In yrs. Ia 1 □ M 21 F 56		Inder 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Mar. 5,		9. Birthplace (State or Fo Country) [aryland
ind at	tor	Usual Residence of Decedent 10a. State 10b. County 1aryland Calv		, Town or Location		Freder	ick		10d. Inside City L
3a or 28s st be not	al Direc	10e. Street and Number 260 Shore Ac	res Way	10	of. Zip Code	678	10	g. Citizen of W	
el', or items ? Exeminer :	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Decedent of Hi , specify Cuba 'es 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		- American Indian, c, White, etc. Black
than "natur be Medical F	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	_	Usual Occupa of work done o OT use retired	ition furing most of won)	king		siness/industry
Mental Hygie irked other i itic event, II	To Be Co	10 17. Father's Name (First, Middle, Las Harold		ills		18. Mother's Nam	ne (First, Middle, N	Home Maiden Sumame Gray	9)
Department of Health and Mental Hygiene. Important: if items 23e or 28e-f show Important: if item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner: ust be notified at once.		19a. Informant's Name/Relationship Donna Jones/Da		19b. Mailing Ad		and Number or Ru Street	ral Route Number, Laurel		
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Speci	Removal from State	ace of Disposition metery, cremator oper s	v or other place	em.4/20	Date 2		city or Town, Stete
		21. Signature of Funeral Service Lice	Level	22. Nar 1 4 5 1	Dare	s of Facility Se	well Fu	neral ince F	Home red.,MD20
ysician Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Utenine	Do not enter the		g, such as cardiac	or respiratory arre	st,	Approximate Interval Betwee Onset and Dea
aminer	e	Sequentially list conditions, if any, leading to immediate cause. Entai Underlying	b. Due to (or as a consequence) Due to (or a consequence)	ience of):					Zyr
icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Sur Ven	ience of):	v tal	chy and	ia		3yrs
hys	ical		d. Anendi						Ayes
fig. this certificate has been signed by the attending ineral director, page 2 should be detached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3 □Ecto	pic pregnancy er (specify)			23d. Date Mon	e of delivery th Day Yea
	by	Part II. Other significant conditions	contributing to death but not resu	ilting in the underl	ying cause give	an in Part I.			bute to the cause of deat
	Completed						24a. Was ar autops perform 1 Yes 2	ped? de	Vere autopsy findings ava rior to completion of caus eath? ☐ Yes 2 2 No
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 🗶 I	ER/Outpatient 3	□ DOA Othe	20	th (Check only one		(0 1)
		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		ome 5 ☐ Reside 28d. Describe ho		
i ji fe	Certification:	3 Suicide 6 Could not determine		me, farm, street, i	actory, office		28f. Location (Str City or Town		r or Rural Route Number
24 hours a	Medical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	Physician: To the best of my know aminer: On the basis of examinat and manner stated.	wledge, death occion and/or investi	urred at the tim gation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and man ite and place, a	nner as stated. nd due to the cause(s)
within 2 To the complet	M	29b. Signature and title of certifier	Ohn D	Z 10	29c. License		29	d. Date signed	(Month, Day, Year)
			1 10000	1000	שטע	56950		11.411	, 2007

			1 - For State Registrer	State of	Maryla	nd / De _l	partment of I	Health a	and M	lental Hygi		5	15216
П	Physici	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month								ear	3. Time of Death		
	/Medic		John		Antko	nrak				May 3,	2005 Year		11:45 p⁴
	Examin	er	4a. Facility Name (If not institution St. Joseph Me				4b. City, Town,		of Death		4c. County of		
	5		5. Social Security Number		Age (In yrs.	last hirthda	Towso		24 Hrs	9 Date of Birth	Balti		
	Funeral Director		215-10-8380	1 M 2 □ F	9		Months Days		Min.	8. Date of Birth (Month, Day, January 2	Year) N 1912	Count Mar	ace (State or Foreign ly) yland
	D		Usual Residence of Decedent	<u></u>						our bidly is	1712		
	arylar show	_	10a. State 10b. County		10c. C	ity, Town or						10	Od. Inside City Limits
	he M	ecto		Ltimore		Timor							1 Tes 2 No
	with the or 3	Funeral Director	10e. Street and Number 2300 Dulaney	Valley Pag	. .		10f. Zip Code	7		10	g. Citizen of Wha		try?
	ns 23	era	11. Marital Status	12. Was Deced		J.S. 1:	2109		igin? (Sne	ocify Ves or No-	U.S.A		an Indian
ထွ	after or iter	Fun	1 Never Married 2 Mar	nied Armed Ford	es? □ No LuLt	1	Was Decedent of I If Yes, specify Cub			Rican, etc.)		White, e	
03	72 hours after death with the Maryland natural, or items 23e or 28a-f show Iteal Examination in wat be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat		<u> </u>	1 ☐ Yes 2√ No	Specify:			Specify:	Wh	nite
5	72 h "natu	Completed by	15. Deceder (Specify only highe	nt's Education st grade completed)		16a. Dec	cedent's Usual Occur ve kind of work done DO NOT use retire	pation during mos	t of worki	ng 1	6b, Kind of Busin	ness/Ind	ustry
12	within ene. than *	mp	Elementary/Secondary (0-12)	College (1-4	lor 5+)	R	. DO NOT use retire CORDS Cle	rk			U.S. G	ovet	roment
d 2	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "naturel", or items 23e or 28e-f show event, the Modical Examiner must be notified at	ပိ	17. Father's Name (First, Middle,	Last)		1		18. Mothe	er's Name	(First, Middle, M			
lan	should be nd Mental markad o	To Be	John	Antkow	iak			Ida		С.	Nitka		
Maryland 21215-0036	shou and N s mai		19a. Informant's Name/Relations	ship (Type, Print)		19b. Ma	iling Address (Street	t and Number	er or Rura	l Route Number,		ite, Zip	Code)
	and Salth n 27 i		Martha T. Ant	kowiak-sis			O Dulaney	Valle	ey Ro	մ., W-30	7, Timon	ium,	MD21093
Baltimore,	ges 1 1 of H		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation	3 □Removal from St	ate	cemetery, c	position (Name of rematory or other pla		D	ate 2	0c. Location - Cit	y or Tov	vn, State
ţ	i. Pag tment tant: ijury c		`4 ☐ Donation 5 ☐ Other (S	Specify)	Dul		lley Mem'l (5/10/0		Timonium		
Bal	permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 is marked any injury or other treumatic events.		21. Signature of Funeral Service	Licensee William	i G. Dau	1	22. Name and Addre 1050 York F	ess of Facili	y Ruc	k Tawson f	uneral Ho	me,]	inc.
			23a. Part1. Enter the disease, or	r complications that cau	used the dea	th. Do not e					et .		Approximate
B			Immediate Cause (Final	only one cause on eac	ch line.		/ /	rig, odon do	our dido o	rospiratory arre	J.,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	aDue to (or	as a conse	quende of):	AV441						2 homs
	Examiner		Sequentially list conditions b Atrial than ((197)									unkunon	
=	D ==	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conse	quence of):	A .						/
V	be executed Ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. 600	mal	41	Usion					le	nlum
8760,	cate be executed physician and s the burial-transit	Ical E		Due to (or	ras a conse	quence or):							
687	The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the			d									
Вох	eath certific attending p I for use as I	/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn						23d. Date of	f deliver	у
	deat	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2∏Fetant at time of		B □Ectopic pregnanc □ Other (specify) _	:y 			Month	[Day Year
P.0	that the de ted by the a detached t	Physiclan/Med	9 Unknown										
	res tha signed	by	Part II. Other significant conditi	ons contributing to dea	th but not re	sulting in the	underlying cause gr	ven in Part I					cause of death?
Sor	w require been si should t	etec								1 Yes	3 2 □ No 3 [Proba	bly 4 Dunknown
Vital Records,	has ge 2 s	Completed							_	24a. Was an autopsy perform	prio	r to com	sy findings available ipletion of cause of
[a]	ician: The contificate has rector, page	e Co	25. Was case referred to medica							1 ☐ Yes 2	☑No 1□	Yes 2	2□ No
>	Physician: r this certifica ral director, i	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	B/Outnati	ent 3 DOA Ott			_(Check only one ne 5 ☐ Resider		Canada	
J of	iding Physician: th. : After this certifica) funeral director, p	n; T	27. Man or of Death 1 Natural 5 □ Pendir	28a. Date of		28b. Time	of 28c. Inju	ry at	-	28d. Describe how		<i>эрөсну)</i>	
Sio	Attending r death. ector: After by the fune	atlo	2 Accident investi	gation	Day roary	irijary		Yes 2	No				
Division	or Att fter d lirect In by 1	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place o	f Injury - At h J, etc. <i>(Speci</i>	nome, farm, : ify)	street, factory, office		2	28f. Location (Stre City or Town,		r Rural	Route Number,
	pitai		29a, Certifier 1 Certifyin	a Shusiaian T. d. t									
	e Hos 24 ho e Fun letely	edical	(Check only 2 Medicel	ng Physician: To the b Examiner: On the bas and manne	is of examina	owledge, de ation and/or	ath occurred at the ti investigation, in my o	me, date an opinion, dea	d place, a th occurre	and due to the caused at the time, da	use(s) and manne te and place, and	due to	ted. the cause(s)
	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifie				29c. Licens	se numioer		29	d. Date signed (A	fonth, D	lay, Year)
			Polina	MD			DE	3440	5	1	lm 05.	20	5
	:0+	-/	30. Name and address of person	who completed cause	of death (Ite	m 23a) (Typ	e, Print)		#31	1 -	100		12 - 1
	10		31. Date filed (Month, Day, Year)	lurner,	M.D),	e, Print) 7600 05	Her D	2	lows	on, INIZ	2	1704
	Sta Registr		MAY 0	5 2005	gistrar's Sign	a cure	(all)						

			1 - For State Registrar	State of Marylar		artment of F		•	•	
	Physic: /Medi		Decedent's Name (First, Middle, L.	Becraf	+	amouto or	- Journ	2. Date of De Month	Pag. No. Day Yeer	3. Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution, g Hopkins Elder Plu 5. Social Security Number 217–12–5659		last birthday)		r Location of Death //S Point if Under 24 Hrs. Hours Min.		4c. County of Death Baltimon th Year) 2, 1921 Unl	CE uplace (State or Foreign
	h the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. Ci	ty. Town or Lo				, , , , ,	10d. Inside City Limits 1 ☼Yes 2 ☐ No
	death with the Maryland rms 23a or 28a-f show r must be notified at	al Director	10e. Street and Number 112 North Highla	and Avenue	Darta	10f. Zip Code 21.2	224		10g. Citizen of What Cou USA	untry?
920	or ite	by Funeral	11. Marital Status 1 Never Married 2 Married Midowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2√2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 챛 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		, etc.
21215-0036	- 2	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occup kind of work done o DO NOT use retired maker	ation during most of work ()	ing	16b. Kind of Business/I	ndustry
Maryland 2	2 should be filed withir and Mental Hygiene. ia marked other than aumatic event, the Mi	To Be Co	17. Father's Name (First, Middle, Las Unk.	st)			18. Mother's Nam	e (First, Middle,	, Maiden Surname)	
	s 1 and f Health item 27 other tr		19a. Informant's Name/Relationship Carolette Baker, 20a. Method of Disposition	Legal Guardian	112 N		land Ave		er, City or Town, State, Zitimore, Mary 20c. Location - City or T	land 21224
Baltimore,	permit. Page Department o Important: If any injury or once.		1 Burial 2 Oremation 3 4 Donation 5 Other (Spec	ensee	tro Cr	ematory I	inc. 05/	03/05 Of Mary	Baltimore, land Inc. ore, Marylar	
V	Personal Purpose of Medical Examiner Purpose of Personal Purpose o	Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying that initiated events resulting in death) Last	mplications that caused the dea	quence of):					Approximate Interval Between Onset and Death
.O. Box 68760	ne death certificate the attending phys thed for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pugnant in the past 12 months? 1 □ Yes 2 10 No 9 □ Unknown	d. 23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 0	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
<u>α</u>	w requires that the bear signed by should be detact		Part II. Other significant conditions	contributing to death but not res	sulting in the u		en in Part I.		obacco use contribute to t	. /
Vital Records,		Completed	history at	Stroke	•	'				opsy findings available impletion of cause of
Division of Vita	ding Phy: h. After this funeral d	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati 2 Accident investigati 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at	me 5 Resid		Assisted
Divi	pital or burs afte eral Dire	al Certifi	4 Homicide determine	28e. Place of Injury - At h building, etc. (Special Physicien: To the best of my known and the second secon	(y) 		e, date and place.	City or Tow		
	To the Hos within 24 hd To the Fun completely	Medical	(Check only one) 2 Medical Execution Medical Execution 29b. Signature and title of certifier	eminer: On the basis of examina and manner stated.	ation and/or inv	estigation, in my op	pinion, death occur	red at the time, o	date and place, and due t	o the cause(s)
	- > - 0		30. Name and address of person who	Completed cause of death (Iter	7 23a) (Type	D 4	5757 stern	?	May 3, Dalt MS	2005
	Sta	te.	Matthew 31. Date filed (Month, Day, Year)	Mc No 4 N 20 32 Registrar's Sign	49	40 Er	stern!	fre	Dalt ms	21224
	Regist			2005	4 la	self A				

			1 - For State Registrar	State of M	larylar			t of H	ealth a	and M		giene Reg. No	200	5. 1521	0
			Decedent's Name (First, Middle, Las EL1ZABETH G. BREEN	t)							2. Date of De Month	ath Day	y Year	3. Time of Death	•
ė	After this cardificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit and incorp. To Be Completed by Dhysician Branch and Be and by Dhysician Branch and Be and		4a. Facility Name (If not institution, give 8801 Brian dale	4)		,		Location o	of Death			County of De		
			5. Social Security Number 6. Se		ge (In yrs. 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da JAN. 23,	th y, Year)	9. B	irthplace (State or Foreign Country) W JERSEY	1
	aryland show	2	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	+
	or 28a-f	Director	MD PRINCE GE 10e. Street and Number	ORGE	LA	NUREL	10f. Zip					-	tizen of What (
	ar deeth w	Funeral	8801 BRIARDALE LANE 11. Marital Status	12. Was Deceden Armed Forces	?	I.S. 13. \	207 Vas Deced f Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)		SA 14. Race - An Black, Wh	nerican Indian, nite, etc.	
9000	hours afte tural', or i	by	1 Never Married 2(X) Married 3 Widowed 4 Divorced	1 Tes 2 X If Yes, Give Year or Dates			I ☐ Yes 2		Specify:			105 1	Specify: W		
1215-	within 72 ene. than "nat	Completed	(Specify only highest grades (0-12)	de completed) College (1-4or	5+)	life. I	kind of wor DO NOT us	k done d	during most	t of workin	ng		and of Busines	s/industry	
and 2		Be	12 17. Father's Name (First, Middle, Last)	3+		TEAC	HEK				(First, Middle,		OUCATION Sumame)		
Mary	d 2 should th and Me ?7 la mark traumati	۲	MARTIN VAN ESS 19a. Informant's Name/Relationship (7 CORNELIUS BREEN / HU						and Numbe		Route Number		or Town, State	, Zip Code)	
	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	,	Place of Dispo	sition (Nam natory or ot	ne of ther plac	θ)		EL, MARY	20c. Lo	ocation - City	or Town, State	
Baltin	permit. P Departme Importani any injuri		21. Signature of Funeral Service Licen	S88	000 8 (22	. Name and	d Addres	s of Facility	y FLE	CK FUNER	RAL HO	OME, INC		
			23a. Part1. Enter the disease, or company speck, or heart failure. List only immediate Cause Final	olications that ause	d the dea	th. Do not ent	er the mode	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between	
	/Medical		disease or condition resulting in death)	Due to (or a				Kra	~J~ V ~ 3	50-01	10 11		2005	y-e	
/	uted id ansit	ımlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. One to (or a	s a sonsec	juanee of):									
8760,	ite be exec iysiclen ar ne burial-ti	ical Ex	resulting in death) Last	Due to (or a	s a consec	quence of):									
.O. Box 68	the death certifics the attending ph ched for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3	Ectopic pre						23d. Date of d Month	elivery Day Year	
0	juires that I n signed by ald be deta	by	Part II. Dther significant conditions of		but not res	sulting in the u	nderlying ca	ause give	en in Part I.			obacco u Yes 2		to the cause of death? Probably 4 Denknown	
α	The law rec ste has bee page 2 shou	Completed									24a. Was autor perfo	osy ormed?	prior to death?		
Ita	ilan: artifica ctor, I	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
<u>\$</u>	hysic lidire	2	1 Yes 2 No	Hospital: 1 Inpat	ient 2	ER/Outpatien	t 3 🗆 DO	A Othe	9r: 4 □ Nu:	rsing Hom	ne 5 Resid	dence	6 □Other (Sp	ecify)	
sion o	anding Pl sath. or: After ti he funera	atlon;	27. Manne-of Death 1 Natural 5 Pending 2 Accident Investigation		ury ay Year)	28b. Time of Injury	M 2	Bc. Injury Work	rat ⟨? Yes 2∐!		8d. Describe I	how injur	ry occurred		
Divis	ital or Att rs after de al Diract led in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	njury - At h atc. <i>(Speci</i>	ome, farm, str	eet, factory	, office		2	8f. Location (3 City or Tox			Rural Route Number,	
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)	ysician: To the bes niner: On the basis and manner s	of examina	owledge, death ation and/or in	estigation,	in my op	pinion, deal	d place, a th occurre	nd due to the	date and	d place, and du	ue to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier Alabata	Abosto	v D				number ンろご	927	•		te signed (Mor		
	10		30. Name and address of person who a	completed cause of	death (Ite	m 23a) (Type,	Print)	ve	ch	eve,	ely 1	MA	y 2, 3		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 5 20	' 3 Regis	trar's Sign	ature &		7		-	7				

			State of Maryland / De	epartment of Health and Mental Certificate of Death	9						
	Physici		1. Decedent's Name (First, Middle, Last) GEORGE E. BAILEY SR.	2. Date Monti	of Death 3. Time of Death						
	/Medic Examin		4a. Facility Name (If not institution, give street and number) North Arundel Hospite 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	4b. City, Town, or Location of Death Glen Burnie	Anne Arunde						
	Funeral Director		215-24-3741 Usual Residence of Decedent	Months Days Hours Min. (Mont	of Birth h, Day, Year) 28 1929 9. Birthplace (State or Foreign Country) MD						
	Maryland B-f ehow	tor	Maryland Anne Arundel	Glen Burnie	10d. Inside City Limits 1 ☐ Yes 2 ☐ No						
	h with the 23a or 28 at be not	al Director	10e. Street and Number 106 Juniper Drive	10f. Zip Code 21060	10g. Citizen of What Country? USA						
920	72 hours after deeth with the Maryland natural; or tema 23s or 28s-f ehow diest Examiner runt ter molitied at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc □ Yes 2 ☑ No Specify:	or No- 14. Race - American Indian, Black, White, etc. Specify: White						
121	within ene. than	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired) Carpenter	16b. Kind of Business/Industry US Government						
/land	be filed trail Hyg and othe event,	To Be C	17. Father's Name (First, Middle, Last) Joseph S. Bailey	18. Mother's Name (First, M Lillian L	iddle, Maiden Sumame) Smith						
	s 1 end 2 should f Health and Mer Item 27 is marks other traumatic		Gisela Bailey (spouse) 10	Mailing Address (Street and Number or Rural Route N 6 Juniper Drive, Glen Bu							
	permit, Pages 1 Department of He Important: If Iter any injury or oth		Durial 2 (X) Cleriation 3 Lineinovaliion State	Disposition (Name of crematory or other place) Crematory Inc. 2005 22. Name and Address of Facility Stall	Baltimore, Maryland ings Funeral Home, P.A.						
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	3111 Mountain Road, P et enter the mode of dying, such as cardiac or respirate Ovostate Concer							
	The law requires that the death certificate be executed was labeled by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	Due to (or as a consequence of Due to (or as a consequence of Social High Cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Cause (Disease):							
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year						
rds, P	w requires that been signed b should be deta	by	Part II. Other significent conditions contributing to death but not resulting in t	the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mno 3 ☐ Probably 4 ☐ Unknown						
		e Completed	25. Was case referred to medical	10							
	Phys rthis ral dii	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	The second secon	Residence 6 Other (Specify)						
27. Manner of Death 1											
_	To the Hospital of within 24 hours of To the Funerel D completely filled in	edical Co	29a. Certifier (Check Gulf) one) 1 Certifying Physician: To the best of my knowledge. 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and due to for investigation, in my opinion, death occurred at the	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)						
	To the within 2 To the comple	Me	29b. Signature and little of certifier dawls mis	29c. License number 00022483	May 2, 2005						
	5		30. Name and address of person who shipleted cause of death (Item 23a) (T STVART JACCBS MD 30S H	ype. Print) Dr. Glen Burn	ie , mb 2106/						
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 5 2005 32. Registrar's Signature	<u> </u>							
DHM	MH 17 Rev 1/2	1001	ORIG	INAL							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Rudo1ph Bailey 339 M 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square
5. Social Security Number Center Himore HUSP tal If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb. 14, 1927 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Days Min. 236-38-9058 1**X** M 2□ F 77 Yrs. **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show or other treumatic event, the Medical Examinar rusal be ristilled at Yes 2□No Director MD N/A Balitmore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1126 Quantril Way 21205 United States Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Internation 27 is marked other then "naturel", or ite 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes a No Specify: Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator National Wire 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Bailey Ora Stover ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other treu Sharon McNish (Daughter) 1049 Quantril Way Balitmore, Maryland 21205 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/1/05 Bate 1 Burial 2 Cremation 3 Removal from State Baltimore-Washington Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22 Name and Address of Facility
Charles S. Zeiler & Son, Inc.
6224 Eastern Avenue Baltimore, MD 21224 21. Signature of Funeral Service Licensee, Evan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3days **Physician** De 0515 /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No 1 Yes 2 No Division of Vital Hospitel or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hours a 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ES00000 completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore, Md 31. Date filed (Month, Day, Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Shirley V. Chick April 25, 2005 9 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1001 Windstream Drive #603 Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 21XF Months 578-34-4638 Director 76 Ju<u>ne</u> Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Itame 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10001 Windstream Drive, #603 21044 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker <u>Own Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental H tant; If Itam 27 is marked off jury or other traumatic evan Be Charles C. Vunck Fannie Garnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Chick-Son 6620 Seneca Farm Road, Columbia, MD. 21046 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Depertment of Important: If any Injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Balto./Wash. Crematory04/30/05 Vash. Crematory04/30/05 Lautel, MD 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service License 7601 Sandy Spring Road, Laurel, Maryland 20707 M00869 Part1. Enter the disease, or configurations, lat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one call on each line. 23a. Part1. Enter Approximate Interval Between Onset and Death inal erebrovascular accident **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transIt Causa (Disease or injure that initiated events resulting in death) Last the attending physician and hed for use as the burial-tran c. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 51a dder cancer 1 Yes 2 No 3 Probably 4 Ninknown Be Completed demenha heimer's 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy performe 1 ☐ Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 20 No 1 🗌 Yes Certification: To this 27. Manner of Sath 28d. escribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: filled in by the 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D61785 Type. Print) Stet-Z Brocklyn Park, MD 21225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hammonds Cane 606 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 5 2005 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Shirley Crabson 05-02914 RJ

2717		1	For State Registrar	State of I	Maryland	-	rtment of I tificate of		Mental Hy	giene Reg. No.	005	15222
F	hysicia	an	1. Decedent's Name (First, Middle, Shir]		Cral	bson			2. Date of De Month April	Day	Yeer	3. Time of Death
, Ft	/Medic Examin uneral rector	er	44. Facility Name (If not institution, 94409 La Plata Ave 5. Social Security Number 220–72–3206	enue. Apar		K ast birthday) Yrs.			s. 8. Date of Bi	4c. C N	Ounty of Death	place (State or Foreign ntry)
D			Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation					10d. Inside City Limits
ө Магу	Be-f sh	Director	Maryland N/A			Balt	imore					1 Yes 2 No
h with th	3a or 2 at be no	ai Dire	10e. Street and Number 4409 LaPlata Av	enue Apt	K		10f. Zip Code 2121	1		10g. Citiz	en of What Cou USA	ntry?
1215-0036 within 72 hours after death with the Maryland ene.	Importent: if tiem 27 is marked other than "natural", or tiems 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status **X-XNever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force d 1 ☐ Yes 2 If Yes, Give Year or Date	s;? ⊡No		Vas Decedent of f Yes, specify Cub I ☐ Yes ŽÃ No		(Specify Yes or Netro Rican, etc.)		4. Race - Ameri Black, White, Specify: W	
21215-0036 sd within 72 hours aflogiene.	han "natur e Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) n/a	Education grade completed) College (1-4	or 5+)	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire Sembly	during most of w	rorking		imes Scl	
land 2: Ild be filed v	ked other I	To Be Co	17. Father's Name (First, Middle, Li Woodrow Cra	,			-Cimb Ly	18. Mother's N Ethe	ame (First, Middle e1 De11	, Maiden S		
Maryland Ind 2 should be file alth and Mental Hy	27 is mar ar treumat		19a. Informant's Name/Relationshi Kimberly Smith	p (Type, Print) Niece					Rura/Route Numt			
Baltimore,	ent: If Item jury or othe		20a. Method of Disposition 1 XDBurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Special Control Con	ecify)		emetery, crem aney V		emorial S	Date 5/2/2005	Timo		aryland
Ball permit	Important in once.		21. Signa und Funeral Service L	3. Ne	nss		sogi rai	ls Koad,	tz Funera Baltimon	re, Ma	me, Inc. aryland	
/M Exa	sician ledical aminer	iner	23a. Part1. Ener the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	a050 Due il (or	as a conseq	uence of):	er the mode of dy	ing, such as card	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
38760, <	physician and s the burial-transit	dicai Examiner	that initiated events resulting in death) Last	cDue to (or	as a conseq	uence of):						
Box 6	the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown		h 2 ∏ Feta nt at time of d	Ideath 3	Ectopic pregnand Other (specify)	СУ		2	3d. Date of deliv Month	very Day Year
ecords, P.O law requires that the	De g	by	Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying cause g	iven in Part I.			se contribute to	the cause of death?
The The	rtificate has been s ctor, page 2 should	Completed							24a. Wa auto per 1 X Yes	s an opsy formed? 2 \(\sqrt{No}		opsy findings available ompletion of cause of
ion of Vital	h. After this ce funeral dire	ation: To Be	25. Was case referred to medical examiner? *XXYes 2 \sum No 27. Manner of Death 1 \sum Natural 5 \sum Pending 2 \sum Accident investig:	28a. Date of (Month,		ER/Outpatier 8b. Time o Injury	Foun 128c. Inju	ther: 4 🗆 Nursing	g Home 5 Res	sidence 6	y occurred ,	M At scene
2 23	affer death. I Director: A Id in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place o	0.0	ome, farm, sti	reet, factory, office)	28f. Location	(Street and	Number or Rui	ral Route Number,
Hospit	Within 24 hours at To the Funeral D completely filled is	edical (Physicien: To the became	is of examina							
To the	To the	Med	29b. Signature and title of certifier	. (200	0		nse number		29d. Date	e signed (Month	. Day, Year)
	۸.		30. Name and address of person v	who completed cause	of death (Iter	n 23a) (Type,		CME		Ari	1 27, 2	005
	10		31. Date filed (Month, Day, Year)	ONICA-PE	olstrar's Sign	ature /	111 Penn	Street	Baltimo	re, M	laryland	21201
*	Regist	ate rar	MAY 0 5	2005	gistrar's Sign	ature Ace						

Amend item#15, perfrit 6443.57/05 II

		State Registrar		Cer	tificate of	Death	Re	g. No. 2 0 1	1 700
Physic	an	1. Decedent's Name (First, Middle, Last,					2. Date of Deatl	Day Year	3. Time of Death
/Medi		estrue cuttlei					May 1	2005	330 A M
Exami	ner	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Death	
		Novthwest tospita 5. Social Security Number 6. Se:		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltim	<u></u>
Funeral Director		085-03-9993 1 ¹]M 21X1F	90 Yrs.	Months Days		03/709/19	15	place (State or Foreig Intry) PA
land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limit
Mary f sho	to	MD BALTIMO	RF	OWINGS MII	1.5				1 ☐ Yes 2 ☑ N
r 28a	Director	10e. Street and Number		0.72.100 1.12	10f. Zîp Code		10	g. Citizen of What Cou	intry?
15 with		4705 CREEKSIDE C	IRCLE		21117			U.S.A.	
72 hours after death with the Maryland neture!', or Items 23e or 28a-f show alsal Examilier roust be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ŧ	Was Decedent of H f Yes, specify Cubi I Yes 2 🕅 No	lispanic Origin? (Spe an, Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WH	
72 hours "neturef",		15. Decedent's Edu	cation	16a. Deced	lent's Usual Occup	ation during most of workii		6b. Kind of Business/li	ndustry
within 7 ene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+	III III	kina of work done DO NOT use retire	during most of workii d)	ng		
filed with Hygiene. ther than	Con	1		RETA	IL CLOTH	ING SALES	1	NOMENS WARE	
e d d	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	laiden Sumame)	
should be and Mental is marked o	မ	HARRY LEONARD		BERNSTI		PAULINE			CRANTZ
d 2 sho h and 7 is mu treum		19a. Informant's Name/Relationship (7)						City or Town, State, Zi	111
s 1 and of Health item 27 other tr		H. LINDA TROPE / D 20a. Method of Disposition	AUGHTER	20b. Place of Dispo-		D		MILLS, MD	
0 0 = =	Ш	1 Burial 2 □ Cremation 3 □ F	/2005	PINELAWN,					
	1	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens		NEW MONTE	. Name and Addre				
permit. Departr Importe any inju		23a. Part1. Enter the disease, or compl	Roul	89	900 REIST	TERSTOWN R	OAD - P	ON & BROS., [KESVILLE,	
Medical Examiner sician and purial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as a	consequence of): consequence of): consequence of):					
eath certificate that attending physical for use as the b	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 M No 9 □ Unknown	d	Fetal death 3	Ectopic pregnancy	,		23d. Date of delin Month	
he dea the at									Day Year
quires that the death cer n signed by the attendir ald be detached for use	d by P	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.		acco use contribute to	the cause of death?
v requires that the d been signed by the should be detached	leted by Pl	avernia		not resulting in the ur	nderlying cause giv	en in Part I.	1 □ Ye	s 2 No 3 Pro	the cause of death? bably 4 (Monknow
e law has b	ompleted by Pl	auomia biliany cin	rhosis		nderlying cause giv	en in Part I.	1 ☐ Ye 24a. Was ar autopsy perform	24b. Were aut prior to co death?	the cause of death? bably 4 Monknov opsy findings availab
The law ate has b page 2 s	e Completed	biliay cin chonic rou 25. Was case referred to medical			nderlying cause giv		1 Ye 24a. Was ar autopsy perform 1 Yes 2	24b. Were aut prior to co death? 1 Yes	the cause of death? bably 4 Monknov opsy findings availat ompletion of cause o
ding Physiclen: The law n. After this certificate has b funeral director, page 2 s	To Be Completed	biliary cin circularia itt	rhosis	GCI CHCY	t 3 DOA Ott	_26. Place of Death er: 4 ☐ Nursing Hor y at 2	1 Ye 24a. Was ar autopsy perform 1 Yes 2 (Check only one me 5 Reside	24b. Were aut prior to co death? 1 Yes	the cause of death? bably 4 Gonknov opsy findings availab ompletion of cause o
ding Physiclen: The law n. After this certificate has b funeral director, page 2 s	Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day 28e. Place of Injury building, etc.	2 ER/Outpatien 28b. Time of Injury y - At home, farm, str. (Specify)	t 3 DOA 28c. Inum Woo M 1 Deet, factory, office	26. Place of Death lef: 4 □ Nursing Hor y at k? Yes 2 □ No	1 Ye 24a. Was ar autopsy perform 1 Yes 2 (Check only one me 5 Reside 28d. Describe ho 28f. Location (Str. City or Town)	24b. Were autroprior to condeath? 1 Yes 24b. Were autroprior to condeath? 1 Yes 1 Yes 24b. Were autroprior to condeath? 1 Yes 2	the cause of death? bably 4 Gonknow opsy findings availab mpletion of cause of 2 No ify) al Route Number,
ding Physiclen: The law n. After this certificate has b funeral director, page 2 s	Certification: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phy	Hospital: 1 Anpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	2 ER/Outpatien 28b. Time of Injury y - At home, farm, str. (Specify) my knowledge, death examination and/or inv	t 3 DOA 28c. Injut Wor M 1 Deet, factory, office	26. Place of Death er: 4 ☐ Nursing Hor y at k? Yes 2 ☐ No 2	1 Ye 24a. Was ar autops; perform 1 Yes 2 (Check only one ne 5 Reside 28d. Describe ho 28f. Location (Str. City or Town)	24b. Were authorior to code ath? 1 Yes Other (Special Virginia)	the cause of death? bably 4 Punknow opsy findings availab ampletion of cause of 2 No fly) al Route Number,
ding Physiclen: The law n. After this certificate has b funeral director, page 2 s	To Be Completed	25. Was case referred to medical examiner? 1	Hospital: 1 Impatient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	2 ER/Outpatien 28b. Time of Injury y - At home, farm, str. (Specify) my knowledge, death examination and/or inv	t 3 DOA 28c. Injut Wor M 1 Deet, factory, office	26. Place of Death er: 4	1 Ye 24a. Was ar autops; perform 1 Yes 2 (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town, and due to the capital at the time, day	24b. Were autroprior to control of death? 24b. Were autroprior to control of death? 1 Yes 20) 24b. Were autroprior to control of death? 1 Yes 20) 24b. Were autroprior to control of death? 24b. Were autroprior to control of death.	the cause of death? bably 4 Monknow opsy findings availab mpletion of cause of 2 No fly) al Route Number, stated. to the cause(s)
Attending Physicien: The law r death. ector: After this certificate has by the funeral director, page 2 s	Certification: To Be Completed	25. Was case referred to medical examiner? 1	Hospital: 1 Impatient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	2 ER/Outpatien 28b. Time of Injury y - At home, farm, str. (Specify) my knowledge, death examination and/or inv	t 3 DOA 28c. Injut Wor M 1 Doest, factory, office a occurred at the tire vestigation, in my compared to the	26. Place of Death er: 4	24a. Was ar autops; perform 1 yes 2 (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town, and due to the caped at the time, day	24b. Were autrofior to control of death? 24b. Were autrofior to control of death? 1 Yes 10) 10 Yes 11 Yes 11 Yes 12 Yes 13 Yes 14 Yes 15 Yes 16 And Number or Rur State)	the cause of death? bably 4 Gonknow opsy findings availably population of cause of 2 No al Route Number, stated. to the cause(s)
To the Hospitei or Attending Physiclen: The law within 24 hours after death. To the Funerel Director: After this certificate has be completely filled in by the funeral director, page 2 s	Certification: To Be Completed	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day 28e. Place of Injury building, etc. resician: To the best of iner: On the basis of and manner state	2 ER/Outpatien Year) 28b. Time of Injury y - At home, farm, str. (Specify) my knowledge, death xamination and/or invad.	t 3 DOA 28c. Injur Wor M 1 Doest, factory, office to occurred at the tire restigation, in my office 29c. Licens	26. Place of Death er: 4 \(\text{Nursing Hor} \) y at k? Yes 2 \(\text{No} \) me, date and place, a pinion, death occurre to number	24a. Was ar autops; perform 1 Yes 2 (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town) and due to the called at the time, day	24b. Were autrofior to code the code th	the cause of death? bably 4 Punknow opsy findings availab ampletion of cause of 2 No al Route Number, stated. to the cause(s)
ding Physiclen: The law n. Atter this certificate has b funeral director, page 2 s	Certification: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who could not be determined	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day 28e. Place of Injury building, etc. resician: To the best of iner: On the basis of and manner state	2 ER/Outpatien 28b. Time of Injury y- At home, farm, str. (Specify) my knowledge, death examination and/or invad. ath (Item 23a) (Type, DULL P. O.G.	t 3 DOA 28c. Injur Wor M 1 Doest, factory, office to occurred at the tire restigation, in my office 29c. Licens	26. Place of Death er: 4 \(\text{Nursing Hor} \) y at k? Yes 2 \(\text{No} \) me, date and place, a pinion, death occurre to number	24a. Was ar autops; perform 1 Yes 2 (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town) and due to the called at the time, day	24b. Were autrofior to control of death? 24b. Were autrofior to control of death? 1 Yes 10) 10 Yes 11 Yes 11 Yes 12 Yes 13 Yes 14 Yes 15 Yes 16 And Number or Rur State)	the cause of death? bably 4 Gonknow opsy findings availab mpletion of cause of 2 No ify) al Route Number, stated. to the cause(s)

		·	For State Registrar	State of Ma	ryland		artmen tificat			nd Me		iene	2005	15221
	Physici /Medio Examin	al er	1. Decedent's Name (First, Middle, Charles 4a. Facility Name (If not institution, Baltiman Rehab. Ha	Joseph J give street and number)			4b. City,	_	Location of	Death	2. Date of Deal Month	Day 4tr	Year 2005 punty of Death N/A	
	Funeral Director		5. Social Security Number 215-12-4002 Usual Residence of Decedent	S. Sex 7. Age	(In yrs. Ia 82	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	B. Date of Birth (Month, Day, May 2,	1923	9. Birth Cou Mary	place (State or Foreign Intry) Land
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other treumatic event, the Madical Evantral must be notified at once.	To Be Completed by Funeral Director	Maryland Baltim 10e. Street and Number 921Arncliffe Ro 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, L. Joseph B. DeK 19a. Informant's Name/Relationshit Gloria DeKowski 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.) 21. Signature of Funeral Service (1) Triollias Grego	ad 12. Was Decedent E Armed Forces? 1 Syes 2 N If Pes, Give Year or Dates: Education grade completed) College (1-4or 54) owski p (Type, Print) , daughter B Removal from State scrip)	Es ver in U.S o 194 194 194	16a. Deced (Give life.) Execu 19b. Mailir 921 Anace of Disponetery, crer	10f. Zip 21 Nas Deced f Yes, spec f Yes, spec i □ Yes dent's Usu kind of wo DO NOT us 1tive ag Address cncli sition (Namatory or o emato	221 dent of History Cubar 22 No al Occupar fr done of se retired, (Street a ffe me of ther place ry In	specify: ation luring most of 18. Mother Juli and Number Road F	is Name (ia Kior Flural Esse)	(First, Middle, I Leper Route Number 8, Mary te	14 Sign 16b. Kind Rea Maiden St. City or Tland 20c. Loca Balti	n of What Cou USA Race - Ameri Black, White Decify: Whi of Business/Ir al Esta Imame) Town, State, Zi 21221 tion - City or T	tean Indian, , etc. te industry te
ox 68/60,	eath certificate be executed attending physician and attending physician and attending physician and attending physician and attended at the burial-transit	n/Medical Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the International Cause) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a	conseque	Do not ent ence of): ence of): ence of):	er the mod	e of dying	g, such as ca	ardiac or	respiratory arre	est,	d. Date of deliv	Approximate Interval Between Onset and Death
Vital Records, P.O. Bo	aw requires that the d is been signed by the 2 should be detached	Completed by Physician/Med	in the past 12 months? 1	1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	ime of dea	ath 5	Ectopic produced of the control of t	ecify)	en in Part I.		1 ☐ Ye	pacco use	Month contribute to I	Day Year the cause of death?
Division of Vital R	ding Physicien: h. After this certifica funeral director, p	Certification; To Be Con	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident 3 Suicide 6 Could not determine	ot be	Year)	28b. Time or Injury	f 2	8c. Injury Work 1 🗆 Y	Nurs	sing Hom 28	Check only on e 5 Reside	e) ence 6 [ow injury content and for	occurred	2 \(\text{No} \) (fy) al Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Co	(Check only 2 Medical E	Physicien: To the best o xeminer: On the basis of and manner state	examinati ed.	on and/or in	vestigation	, in my op	oinion, death	occurred	d at the time, d	ate and pl	ad manner as a ace, and due to signed (Month,	o the cause(s)
	Sta Regist		30. Name and address of person w Lynn Holla 31. Date filed (Mon May Yar5	Closumon ho completed cause of de 2005 32 Registra	ath (Item	23a) (Type, h Ra	Print)	Blue	Ba	14:0	noch,	Mar	gland	Z1Z18

		1 - For State Registrar	State of Mai		ertificate				Reg. No.	105	15225
Physic	ian	1. Decedent's Name (First, Middle, L			Die	15.4	IAN	2. Date of Month	Day	Year	3. Time of Death
/Med	cal	4a. Facility Name (If not institution, gi	AbINA		DIS			APRI			4. 261
Exami	Physician and Mental Hygiene. To Be Completed Examiner. To Be Completed Examiner are the burner in the activity of other freumatic avent, the Mental Examiner and India of the activity of other freumatic avent, the Mental Examiner and India of the activity of other freumatic avent, the Mental Examiner and India of the activity of other freumatic avent, the Mental Examiner and India of the activity o	NUTETIA ARUNTAL					Location of D	eam			1300
Funeral				(In yrs. last birthda) If Under	1 Year	If Under 24 I	Hrs. 8. Date of		Anno. Day Year 2005 4: 26 4c. Country of Death 2004: 26 4c. Country of Death 3. Time of Death 2005 21: 26 4c. Country of Death 3. Time of Death 2005 21: 26 Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White En Sumame) a Cki yor Town, State, Zip Code) MD 21122 Location - City or Town, State 1en Burnie, MI Funeral Home, dena, MD 21122 Location - City or Town, State 1en Burnie, MI Funeral Home, dena, MD 21122 Approximate Interval Between Onset and Death? Approximate Interval Between Onset and Death? 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 24b. Were autopsy findings averaged and Death? 1 Yes 2 No 6 Other (Specify) 1 yes 2 No 6 Other (Specify) 1 yes 2 No 221 30 ; 22055	
Director		218-05-6735	1□M 2 X F	86 Yrs.	Months	Days	Hours A	01/2	Birth Day, Year) 0/1919	Coun	
p .		Usual Residence of Decedent 10a. State 10b. County		10. Ch. T.							
shoved at	ក			10c. City, Town or						1	0d. Inside City Limits 1 ☐ Yes 2 Mo
the N	ecte	MD Anne A	rundel	Pasad	ena 10f. Zip	Codo			10a Citiman	-/ 14/5 - 1 0	
with B or	ā	7902 Elizabeth	Poad			112	2				itry?
death ms 23	era	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13				? (Specify Yes or uerto Rican, etc.)			an Indian.
iled within 72 hours after death with the Maryland Hygiene. Whylene. Sther than "netural", or Items 23a or 28a-f show ent, the Modical Examinational Legicolined at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, spec		n, Mexican, Po Specify:	uerto Ricán, etc.)			
72 ho	ted	15. Decedent's 8 (Specify only highest g.	Education	16a. Dec	edent's Usua	I Occupa	ation	washing	16b. Kind o	f Business/Inc	dustry
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	npie	Elementary/Secondary (0-12)	College (1-4or 5+)) life	DO NOT us	se retired	furing most of	working			
led w lygier her th	O	8		H	omema	ker					
ed fa b y	0	17. Father's Name (First, Middle, Las						Name (First, Midd		•	
should nd Men marke	2	Albin Lechowi 19a. Informant's Name/Relationship		10h Ma	lina Addrosa	(Ctract o		neira S		=	0.43
d 2 s th an th an treur		Bruce Dishman		1							
1 and I Health Item 27 other tr	1 3	20a. Method of Disposition	, 5011	20b. Place of Dis	osition (Nan	ne of	1	Date			
Page: ent o nt: If		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		1	ematory or o			5/04/05	Glen	Burn	ie. MD
Definition Department of mportent: If it is not injury or o	1	21. Signature of Funeral Service Lice	**								
2 88 8 8		The Sou									
		23a. Part1. Enter the disease, or con shock, or heart failure. List ont	nplications that caused to y one cause on each line	he death. Do not e	nter the mod	e of dying	g, such as car	diac or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a COTONAR	Y RRITE	ול די	SERS	32				Onset and Death
Examiner			b	consequence of):							
) ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
be executed ician and burial-transit	хап	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence of):							
te be exysician		(d								
tificate g phy as the	edi		u								
The law requires that the death certifica the bas been signed by the attending pheage 2 should be detached for use as the	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic pro	eonanov.			23d.	Date of delive	ry
b deal	sicis	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnant at til		Other (spe				-	Month	Day Year
at the d by the letache	Phy	9 Unknown		and see this size the			to Do M	00- D	44-4		
res the signer	b	Part II. Other significant conditions CMZCMC ATC			underlying ca	ause give	en in Part I.				,
redu	etec			CATIVO				_			abiy 4 profittiowi
D 00 00 00	mpi	SICK SINUS	Morrons						topsy formed2	prior to con	osy findings available apletion of cause of
Licien: Tricerificate	ပိ	OF Man and referred to medical	T					1 ☐ Yes	2 2 No		2 No
Itending Physicien: The Islam. Seath. Tor: After this certificate his the funeral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2 V ER/Outpati	ent 3 DO	A Othe		Death (Check on)		045	
g Phy er this	-	27. Manner of Death	28a. Date of Injury	28b. Time	of 2	8c. Injury	at		e how injury oc		"
ath.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigati	on (Month, Day)	Year) Injury	М	Work	Yes 2□No				
lor Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not 4 Homicide determine			treet, factory	, office			(Street and Nu Town, State)	mber or Rura	Route Number,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying F	hysician: To the best of	my knowledge, de	th occurred	at the tim	e, date and pl	ace, and due to the	ne cause(s) and	manner as st	ated.
the Hin 24 the Fi	ledicai	one)	and manner state	examination and/or ed.	nvestigation,	еп ту ор	oinion, death o	ccurred at the tim	e, date and plac	e, and due to	the cause(s)
Vith To 1	Σ	29b. Signature and title of certain	M D				number	,			
Į.		> Jul MM	·				_	1		- 30;	2005
M		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	RIAN	CEL 1	MARYI		10. 21061		
S	ate	31. Date filed (Month, Day, Year)	32. Registrar		75.014				1001		
Regis		ERRY A	2005	-	And H	,					
DHMH 17 Rev 1/	2001	WAY U 5	ZUUS STEEL	150 150 1			·····				
				ORIGIN	AL						

			1 - For State Registrar	State o	f Marylar		artment of tificate of				giene ()	05	15226
	Physicia	an	Decedent's Name (First, Middle, Las.		1					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Daniel Hen 4a. Facility Name (If not institution, give				4b. City, Town,	or Logation 4	of Dooth	M	AY 1,	2005 y of Death	9:45P M
E	Examin	er	Saint Joseph	Medic	al Cer	nter		T	0W50			Balt	imore
	Funeral Director		5. Social Security Number 6. Se	X M 2□F	7. Age (In yrs.	iast birthday) 72 Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Birtl (Month, Da)	r, Year)	9. Birthp	lace (State or Foreign try)
			Usual Residence of Decedent			12			F	April 2	9,1933	NY	
-	show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
1	8a-fs	Director	MD Balti	more		Cocke	eysville						1 ☐ Yes 2X No
1	a or 2	급	10e. Street and Number				10f. Zip Code				10g. Citizen of		itry?
	oeain wiin ine maryland ms 23a or 28a-f show r must be notified at	Funeral	5 Fireoak Ct.	12. Was Dece	edent Ever in U	S. 13 1	Vas Decedent of	030 Hispanic Ori	ain? (Spec	ify Ves or No-	USA 14 Ba	ce - Americ	an Indian
0	r iten	Fun	1 ☐ Never Married 2 📉 Married	Armed Fo	rces? 2 ☐ No		f Yes, specify Cu	ban, Mexican	i, Puerto R	lican, etc.)	Bla	ick, White,	etc.
3	rel', o	i by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ates: 52 -	-61 '	1∐Yes 2∭XNo	Specify:			Specia	v: Whit	e
ה ה	natu dical	Completed	15. Decedent's Ed (Specify only highest grad			(Give	dent's Usual Occu	e durina mosi	t of workin	g	16b. Kind of E	Business/Inc	dustry
7	than than	mpl	Elementary/Secondary (0-12)	College (1		inte. i	DO NOT use retir	ed)			_		
V -	2 should be blied within 72 hours after death with the marylan and Menhal Hygiene. Is marked other than "naturel", or liems 23a or 28a-f show eumstic event, the Medical Eventral must be notified at	Co	17. Father's Name (First, Middle, Last)		ł	Eng	gineer	18. Mothe	r's Name	(First. Middle	Maiden Sumai	Spice	
and	id be ental ked o	To Be	Henry Dudek								peicher		
	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic	۲	19a. Informant's Name/Relationship (7	ype, Print)	·	19b. Mailir	ng Address (Stree	- Contract					Code)
	1 and 2 Health a em 27 ls	8	Marjorie Dudek/W	ife		5 Fin	reoak Ct	. Coc	keysv	ille,	MD 2103	30	
D.	es 1 and of Health of Health filem 27 r other tr		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □	Domoval from	20b. F	Place of Dispo	sition (Name of natory or other pl		Da	2005	20c. Location		wn, State
Saltimo	rages ment of ent: If it ury or o		`4 □Donation 5 □ Other (Specify		Men	aney v norial	Gardens	,	ر در س	2003	Timoni	lum, M	ID .
	permit. Pages Depertment of the Importent: If Ite Importent: If Ite any injury or or		21. Signature of Funeral Samos Licens		,	Le Le	Name and Addington Fu	ess of Facilit nera1	y Home	of Dul	anev Va	11ev.	Inc.
	20 = a 0			1 J. F1		110) W. Pad	onia R	oad	Timoni	um, MD	21093	- 167
F	hysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on e	each line.	in. Do not ent	er the mode or dy	ing, such as	cardiacor	respiratory an	rest,		Approximate Interval Between Onset and Death WEEKS
١,	/Medical Examiner		resulting in death)		(or as a conseq								7 7 444 444 7 4 444
	- Administr	_	Sequentially list conditions,	b	UMONIF							_	WEEKS
	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 1	or as a conseq	juence or).						- 4	
5	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	Due to ((or as a conseq	uence of):							
0/0/	ate be nysicié he bu	dical		d									
٥	death certificate e attending phys id for use as the	Med	IF FEMALE:							.,			
Š į	eath certific attending p	cian/Me	in the past 12 months?	1 Live b	come of pregna with 2 Teta	aldeath 3 [Ectopic pregnan	су				ate of delive onth	ry Day Year
5	the de	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregn 9⊟Unkno	ant at time of down	leath 5	Other (specify)						
Ž	requires that the de een signed by the a hould be detached t	Δ.	Part II. Other significant conditions co	ntributing to de	eath but not res	sulting in the u	nderlying cause g	ıven in Part I.		23e. Did to	bacco use con	tribute to th	e cause of death?
ecords	quires n sign uld be	ed by	CARCINOMA OF T	HE PANC	REAS					1□Y	es 2 No	3 Prob	ably 4 Unknown
0	≥ 0.00	pleted								24a. Was a	an 24b.	Were autop	osy findings available
ב ,	icten: The la certificate has rector, page 2	ompl								autop: perfor	sy πiedi? 2.Δ.I.No	prior to con death? 1 Yes	npletion of cause of 2 No
VITAL	ysicien: is certifica director. I	BeC	25. Was case reterred to medical examiner?					26. Place	of Death	(Check only or	/ \		
_	ys dis	은	1 ☐ Yes 2 No			ER/Outpatien	A SU DOA				ence 6 Oth)
טם:	After After funera	lon:	27. Mapner of Death 1 Natural 5 □ Pending	28a. Di te (Moni	of Injury th, Day Year)	28b. Time of Injury	W	ork?		3d. Describe h	ow injury occur	red	
UNISION	death ctor: y the	ertification:	Accident investigation 3 Suicide 6 Could not be	28e. Place	of Injury - At h	ome larm str	eet, factory, office	Yes 2 1	_	Rf Location (S	treet and Num	her or Rura	l Route Number.
≧ ີ	after after Dire	ertil	4 Homicide determined	buildi	ng, etc. (Specil	fy)	out, factory, office	,		City or Tow	n, State)	Jer or Flura	Trodie Waliber,
	he Hospitel of Attending Phin 24 hours after death. he Funerel Director: After the pletsly filled in by the funeral	al C	29a. Certifier 1 Certifying Phy	sician: To the	best of my kno	owledge, death	occurred at the	time, date an	d place, ar	nd due to the o	ause(s) and m	anner as st	ated.
:	To the Hosp within 24 ho To the Func completely f	edical	(Check only 3 Medical Examone)	i ner: On the b	asis of examina ner stated.	ation and/or in	vestigation, in my	opinion, deal	th occurred	d at the time, o	late and place,	and due to	the cause(s)
i	To the within 2 To the complete	Σ	29b. Signature and title of certifier	000.	11	λ	29c. Licer	se number		2	29d. Date signe	ed (Month, L	Day, Year)
			P H. J. H	rey	. NI.	-	D	17695		/	vay i	120	005
	P		30. Name and address of person who o	ompleted caus	se of death (Iter	m 23a) (Type,	Print)						
	Sta	10	ARDALIAH J. HE 31. Date filed (Month, Day, Year)		M. D.		OSLER	DRIVE	_TOW	SON, I	4ARYLA	ND 2	1204
, Spi	Sta Registr		MAY 0 5 20	A.		12 A	calle D						

		Registrar Decedent's Name (First, Middle	em 23a,27,28			Tillicate of t	Jeani	2. Date of D		2007	2 75-17-17
Physician	ľ	Karen	Ann			DeLorenzo	,	Month May	Day 01	2005	3. Time of Death 12:31 PM
/Medical Examiner	4	a. Facility Name (If not institution				4b. City, Town, or				County of Death	
		North Arundel H	Hospital			Glen Bu			1	Anne Aru	ındel
ıneral	5	. Social Security Number	6. Sex 7. Ag 1 M 2 1 F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	in (Month, I	Day Year)	9. Birth	place (State or Foreign intry)
ector	-	216-15-1432 Usual Residence of Decedent	A	29	113.		<u> </u>	Nov.	10,19	/5 Wasi	nington, DO
a .		0a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
ctor			e Georges	Во	wie						1 ☐ Yes 2 X No
or other traumatic avant, the Medical Evanirat russt be mulified at To Be Completed by Funeral Director	1	Oe. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	untry?
Funeral Director	-	2210 Harwood L. 1. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cuba		(Specify Yes or N	10-	USA 14. Race - Amer	ican Indian,
by Fun		1 Never Married XXMarri 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X If Yes, Give Year or Dates:			If Yes, specify Cuba 1 ☐ Yes 2 XX No	n, Mexican, Pu Specify:	ièrto Rican, etc.)		Black, White Specify: Wh	nite
Completed		15. Decedent (Specify only highes			(Give	dent's Usual Occup- kind of work done	during most of	working	16b. K	ind of Business/I	ndustry
mpigm	-	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	1)		7777	4.0	
ပိ		12 17. Father's Name (First, Middle, i	Last)		UIIIC	e Manager		Name (First, Midd	HV le. Maiden		
To Be		Richard Thierj	ung				Betty	Bell Kul	nn		
E L		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (Street	and Number or	Rural Route Num	ber, City o	or Town, State, Zi	ip Code)
	-	John DeLorenzo	, Jr. (Husba		_	1 Redland	ls Road	The second second			
5	2	20a. Method of Disposition XXBurial 2 Cremation		-	cemetery, cre	osition (Name of matory or other place		Date		ocation - City or T	
i i	T	 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service 		Ma		Vet. Cen		5-2005	_	wnsville	e, MD
any Injury or othar trat	1	13- g.C	<i>§</i> —			R. Name and Address Hardesty 12 Ridgel	y Aveni	ie, Annaj	polis	, MD 214	401
-50		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each li	d the deat ine.	th. Do not en	ter the mode of dyin	g, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
ical	I	Immediate Cause (Final disease or condition resulting in death)	Combined		-	codone an	d mepro	obamate)i	ntox	ication	Onoor and Double
ner		,	Due to (or as	a consec	quence of):						
je 🚾	L	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a cons	neuca ot):						
Examiner		that initiated events	c								
		resulting in death) Last	Due to (or as	a conseq	quence of):						
			d								
of for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of deliv	/ery
sician/M		in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			□Ectopic pregnancy □ Other <i>(specify)</i>	'			Month	Day Year
Physi		9 Unknown									
d by		Part II. Other significant condition	ins contributing to death t	out not res	sulting in the u	inderlying cause giv	en in Part I.				the cause of death? bably 4 Unknown
age 2 should ompleted								24a. Wa	is an	24b. Were aut	opsy findings available
age 2	-							. ∪ per	opsy formed? 2 ☐ No	prior to o	ompletion of cause of
Be C		25. Was case referred to medical examiner?					26. Place of I	Death (Check only		1 1 1 1 1 1 1	20.10
	2	TX Yes 2 No	- 1		ER/Outpatie		4 🗆 Nursin	g Home 5□Re	sidence	6 ▼ Other (Spec	Scene .
ion:		27. Manner of Death 1 □ Natural 5 □ Pendin		ıry ıy Year)	28b. Time o	Wor	k?	28d. Describe	e how injui	ry occurred	unk
ertification;		2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i	J-1-03	iurv - At h	11:42	A	Yes 2 No	28f. Location	(Street an	nd Number or Rui	ral Route Number,
d in by		4 Homicide determ	Found at	c. (Speci	idence	reet, factory, office		Crofton	own, State	⁹ 1434 Ha	rwick Cour
completely filled in by the funeral director, page 2 should be detached for use a Medical Certification; To Be Completed by Physician/M.	3	(Check only XXMedical	g Physician: To the best Examiner: On the basis of	of my kno	owledge, deat	h occurred at the tin	ne, date and pla pinion, death o	ace, and due to th	e cause(s)	and manner as	stated. to the cause(s)
Med		one) 29b. Signature and title of certifie	and manner st	ated.		29c. Licens	e number		29d. Da	te signed (Month	, Day, Year)
Ö			, m.D			C	OCME			y 02, 20	
		30. Name and address of person	who completed cause of	death (Iter	m 23a) (Type,	Print)					
		30. Name and address of person	who completed cause of	death (Iter	m 23a) (Type,		n Stree	et Balti	imore	, Maryla	and 21201

Amend item#Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Fime of Death. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2005 EISLER BERMARD 02 MAY /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 29, 1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Days Hours Min Yrs. 051-12-4047 82 NY **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No by Funeral Director N/A LYNCHBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 230 1971 UNIVERSITY BOULEVARD 24502 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE 3X Widowed 4.X Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", enry injury or other traumatic event, if w. Alical Exagnce. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) NUCLEAR FACILITY Elementary/Secondary (0-12) College (1-4or 5+) MANAGER BABCOCK WILCOX 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STREIM ISAAC EISLER TEMA CHAIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 COURTYARD CIRCLE - BALTIMORE, MD 21208 JOEL EISLER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) SHOLOM 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3, X Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) BETH JOSEPH AGUDATH + 05/05/2005 AMHERST COUNTY, VA 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ZMVana Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Congestive disease or condition resulting in death) HEART FAILURE /Medical Due to (or as a consequence of): **Examiner** MEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical SAMORE IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2) No Hospitel or Attending Physicien: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) axaminer' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 No 1 ≰Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 2 Accident Injury 5 Pending r death 1 ☐ Yes 2 ☐ No investigation hours after deat unerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide within 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 2 0 mehla mo May 02ho D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER RAMORIUS TOLIN HOSPITAL REMJER MORTH LIEST 31. Date filed (Month, Day, Year) 732. Registrar's Signature State MAY 0 5 2005 Registrar

05-3041 B.K.S OSCAR FISHER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stata Registrar amend ite		aryland / Depa Th g843 5/ 0			ental Hygiene Reg. No		
	Physici	an	1. Decedent's Name (First, Middle, Las		8-1-1		2	2. Date of Death Month Da	Z U U) Year	3. Time of Death
	/Medic	al	Oscar Fisher 4a. Facility Name (If not institution, give	street and number)		4h City Tayya		MAY 2,20		0843 A M
1	Examir	er	SINAI HOSPITAL	street and number)			ORE CITY	40	c. County of Death	
	Funeral		Social Security Number 6. Security Number		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8	B. Dete-of Birth	9. Birthr	place (State or Foreign
	Director		238-88-7383	M 2□F 5	O Yrs.	Months Days	Hours Min.	(Month, Day, Year, 0/ 18 /1954		h Carolina
	and 1		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation		27		Od. Inside City Limits
	vith the Marylan or 28a-f show ce notified at	tor	Maryland							1X□Yes 2□No
	ith the Ma or 28a-f	Director	10e. Street and Number		Baltimor	10f. Zip Code		10g. Ci	tizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show fmust be rotified at		3030 Spaulding Av	enue Ap	ot. 12	2121	5	U.:	S.A.	
36	after or Ite	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	lo	Was Decedent of F f Yes, specify Cub 1 ☐ Yes 2 🕅 No	Hispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: R1	
8	72 hours 'natural', dical Exa		15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occur	pation	16h K	(ind of Business/In	
Maryland 21215-0036	l within iene. r than '	Completed	(Specify only highest gra	de completed) College (1-4or 5	(Give	kind of work done DO NOT use retire	aurina most of working			<u>Cafeteria</u>
þ	Hyg Hyg ent,	Be C	17. Father's Name (First, Middle, Last)			OK	18. Mother's Name (Careteria
ylar	2 should be and Mental Is marked o	ToE	Lloyd Fisher				Rosalee Re	esper		
lar	de la la		19a. Informant's Name/Relationship (7	ype, Print)			and Number or Rural I			
	1 and Health em 27 ther t		Frederick Fisher	Brother	207 L 20b. Place of Dispo	and the second s	Place, Eng		New Jerse	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 th any injury or other tre 900.9.		1 Surial 2 □ Cremation 3 1 \(\) 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crer	natory or other pla	ce)	200. 2		
ij	artme orten injury		21. Signature of Funeral Service Licen		Hudnell C		U5/U// ess of FacilityThe	2005 Bayb	Joro, Nor	th Carolina
ä	Depa Impo any ir		Man C	1			Hgts. Ave.			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do not ent					Approximate Interval Between
	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. Attract	a consequence of):	andiova	iseular di	sease		Onset and Death
	Examiner	e	Sequentially list conditions,	b	- Security 11 (200 - 120)					
/	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s consequence of):					
Ć,	icate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
68760,	ysicie	edical		d.						
	ntifica ng ph s as th		IF FEMALE:							
O. Box	requires that the death certificate be executeen signed by the attending physicien and nould be detached for use as the burial-trans	Physician/M	23b. Was decedent pregnant In the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
<u>α</u>	res that the igned by be detaction	by Pr	Part II. Other significant conditions of	ntributing to death be	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
ď	w require been sig should b							1 ☐ Yes 2	□No 3□Prob	ably 4 DUnknown
I Records,	e law has b je 2 st	Completed						24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
Vital	ysicien: The is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death (
of	this aldi	2	1X Yes 2 No	Hospital: 1 Inpatie			4 Nursing Home	5 Residence		1)
no	ding After fune	Certification;	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Wor	yat 28 k? Yes 2 □ No	d. Describe how inju	ry occurred	
Division	Attending ar death. rector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	-	ury - At home, farm, str			f. Location (Street ar	nd Number or Rura	I Route Number
Ö	s after	Serti	4 Homicide determined	building, etc	C. (Specify)			City or Town, State	3)	,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (rsician: To the best of iner: On the basis of and manner sta	of my knowledge, death examination and/or in- ted.	occurred at the tir restigation, in my o	me, date and place, and pinion, death occurred	d due to the cause(s at the time, date and) and manner as st d place, and due to	ated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Licens			te signed (Month, I	- '
•	, í		Jackar 1	Ireens	ennin	0.C.1	M.E	MAY	7 2, 200	5
W	H		30. Name and address of person who can tash a LGVRR	ibera M.C), 111 PEN		, BALTIMORI	E, MARYLAND	21201	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 200	2. Registra	r's Signature	W				

			For State Registrar	State of	Maryland		artment <i>rtificate</i>			nd Me		giene)	05	15230
			1. Decedent's Name (First, Middle, Las	t)						2	. Date of Dea	th	.,	3. Time of Death
	Physici		Henry Joseph Fa	clev						ı	Month Aay 3,	2005	Year	9:15 AM
	/Medic Examin		4a. Facility Name (If not institution, give		ber)		4b. City, To	own, or Lo	cation of				nty of Death	
1	4	•	5820 Comstock Ave	enue			Balti	more				Ва	ltimor	:e
	Funeral		Social Security Number 6. Security Number		. Age (In yrs. la	ast birthday)	If Under 1 Months		Under 2 Hours		Date of Birth	Year)	9. Birth	place (State or Foreign
	Director		236-22-9862	© M 2□ F	80	Yrs.	WOTHITS	Jays	10013	1	(Month, Day L0/20/1	924		Virginia
	p .		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Lo	ention							10d. Inside City Limits
	show	5	MD Baltime	ro		Baltim								1 ☐ Yes 2 ☑ No
	28e-f	ect	10e. Street and Number		1	Jaicin	10f. Zip C	ode				10g. Citizen	of What Cou	
	within 72 hours atter death with the Maryland ane. then "natural", or Items 23e or 28e-f show ta Madical Examirar must be notified at	Completed by Funeral Director	5820 Comstock Ave	nua			101. ZIP C	2120	6			U.S		nu y :
	eath	erai	11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13. V	Was Decede			in? (Speci	fv Yes or No-		ace - Ameri	can Indian
	tter d	F	1 ☐ Never Married 2 ☐ Married	Armed Ford	es?		f Yes, specif	y Cuban, i	Mexican,	Puerto Ri	fy Yes or No- can, etc.)	E	Black, White,	
936	urs al	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dat			1 ☐ Yes 2¾	No S	Specify:			Spe	city: Wh	ite
21215-0036	72 hours atter dea "natural", or Items	ted	15. Decedent's Ed			16a. Deced	dent's Usual	Occupatio	n	-4		16b. Kind of	f Business/In	ndustry
215	Pin 7	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-	4or 5+)	life. I	kind of work DO NOT use	retired)	ng most	or working				
21	giene giene er th	Son	77			Cran	e Oper	ator				Stee	1 Comp	any
p	al Hy al Hy I oth	Be (17. Father's Name (First, Middle, Last)								First, Middle,	Maiden Sum	name)	
<u>a</u>	Ment Ment arked	2	Joesephas Far	Ley		,			Sara	h Mck	Kenny			
Maryland	ges 1 and 2 should be filed within 72 hours atter death with the Maryla it of Heath and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28e-f show or other traumatic event, it a Medical Examinal must be notified at	9	19a. Informant's Name/Relationship (7	ype, Print)		1					Route Numbe			,
	and ealth n 27 er tr	, y	Joseph Farley						Terr		-			d 21206
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra <u>once</u> .		20a. Method of Disposition 1 Strain 2 ☐ Cremation 3 ☐	Removal from S		ace of Dispo metery, cren	sition (Name natory or oth	of er place)	5	Dat	10	20c. Locatio	on - City or To	own, State
Ë	Pag ment ant: ury c		4 □ Donation 5 □ Other (Specify			Ly Ros	ary		i	5/6/0)5	Balti	more,	Maryland
alt	Departi Departi Import any Inj pnce.		21. Signature of Fundin Service Licen	see		22	2. Name and	Address o	of Facility	Mill	ler-Dip	pel F	uneral	Home Inc.
_	207 29		Total &				6415 E	elai	r Ro					21206
	Physician		231. Pair1. Entir the disease, or comp shock, or heaft failure. List only Immediate Cause (Final disease or condition	one cause on ea	ch line.								,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (o	ras a consequ	ence of):	174	110	LIVI	I TIME	7 41	31 9 31		1-(171)
	Examiner		Conventially list and disings	b										
/	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consequ	ence of):						_		
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
90,	o exe	E	resulting in death) Last	Due to (o	r as a consequ	ence of):								
8760,	ate b	dicai	•	d										
9	he death certitics rithe attending pt ched for use as t	0 1	IF FEMALE:	23a If upa outo										
Вох	The law requires that the death certitic tens been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal nt at time of de	death 3	Ectopic preg						Date of deliv Month	ery Day Year
Ö	res that the de signed by the a l be detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov		aui 5	Other (spec	;Hy)						
P.O.	that the by detact	Ph	Part II. Dther significant conditions c	ontributing to dea	ath but not resul	Iting in the u	nderlying cau	ise given i	n Part I.		23e. Did to	bacco use co	ontribute to t	he cause of death?
Records,	sign d be	Completed by	AS	89578	515						ALIV	es 2 No	3 Prot	oably 4 Unknown
ŏ	w require been si should I	ete	O.A.	er dene	A1. A			-			24a. Was a	24	h 18/200 2000	and the state of a state of the
Re	has ge 2	ш	7///01	cy rejyiv	01/						autop:	sy	prior to co	ppsy findings available impletion of cause of
											1 ☐ Yes	2 No	1 ☐ Yes	€ No
Vital	Physician: The law this certificate has I ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Other			Check only or			
of	this ald	. To	1 Yes 2 No 27, Manner of Death	1 ∐ In 28a. Date of	Injury	28b. Time of		1			d. Describe h			(y)
on	ding h. Atte	tion	1 Natural 5 ☐ Pending	(Month	, Day Year)	Injury	м	injury al Work? 1 ☐ Yes	2 🗆 N	1				
Division of	Attending r death. ector: Attel	fica	3 ☐ Suicide 6 ☐ Could not be	28 <i>e</i> . Place o	of Injury - At hor	me, farm, str	eet, factory,						mber or Rura	al Route Number,
Θį	after Dire	erti	4 Homicide determined	buildin	g. etc. (Specify))	,,				City or Tow	n, State)		
	To the Hospitel or Attending I within 24 hours atter death. To the Funeral Director: Atter completely tilled in by the tuner	Medical Certification:	29a. Certifier Certifying Ph	ysicien: To the t	est of my know	vledge, deatl	n occurred at	the time.	date and	place, an	d due to the c	ause(s) and	manner as s	stated.
	e Ho Fu	dic	(Check only 2 Medical Examone)	niner: On the bas and manne	sis of examinati	ion and/or in	vestigation, ii	n my opini	on, deat	h occurred	at the time, o	late and place	e, and due to	o the cause(s)
	To th withir To th somp	Me	29b. Signature and title of certifier	0			29c.	License nu	umber		2	29d. Date sig	ned (Month,	Day, Year)
			1 Tru &	Corn	2		D	76	271	/		5/4	105	•
	10		30. Name and address of person who	completed cause		23а) (Туре,	Print)			. /				
	V		GOOME LON	0	760	2-Bel	gin 1	ld	Aq.	Ho	ung V	Un Z	1230	2
	Sta	atė	31. Date filed (Month, Day, Year)		gistrar's Signati	erure								
	Regist	rar	MAY 0 5 2005	A Section	الكر ما	A234	AU.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Year Beatrice Graglia 3,2005 5:00a May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Potomac Rebecca House If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 💢 F 154-18-2833 82 Director 8/16/1922 Fairview, NJ Usual Residence of Decedent 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event. It is Nedical Exertical near be notified at Bethesda MD Montgomery 1 ☐Yes X☐No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20817 5327 Goldsboro Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Book Store Proprietor 12 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Caterina Guzzo Antonio Dalla Costa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5327 Goldsboro Road Bethesda, Md 20817 Antonia Gordon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation ← 5 ☐ Other (Specify) 5/07/2005 Fort Lee, N.J. Madonna Cem, Maus. 21. Signatur / Funeral Service Liven ee PHILIP D. RINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 9241 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebra thrombosis /Medical Due to (or as a consequence of) Examiner Arteriose le roitic Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of, Completed by Physician/Medical Examiner burial-transit Due to (or as a consequence of) use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 22100 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) VYSSLTED Hospital: Other: 4 Nursing Home 5 Residence 6 Stother (Specify) 1 Inpatient 2 1 ☐ Yes 2 2 ▼ 0 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No death. М 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed Box 68760. Records, P.O. Division of Vital To the Hospital or Attending Physician:

with the Maryland

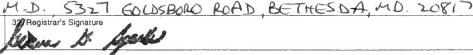
Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year) MAY 0 5 2005

29b. Signature and tille of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O. GOLDON

29c. License number

D0007932

29d. Date signed (Month, Day, Year)

			For State Registrar		State of M		d / Depa		t of H	ealth a		•		e 20	05	1523
			1. Decedent's Name	(First, Middle, La	st)							2. Date of De			·	3. Time of Death
	Physici /Medio		David	Rando	1ph	Gr	ice					Month May	2	200	/өаг) 5	3:30 P M
	Examir		4a. Facility Name (If I	not institution, giv	e street and number)			4b. City,	Town, or	Location o	f Death		40	c. County of	Death	
			1036 6th	Street				G1	en B	urnie	2			Anr	ie A	runde1
	Funeral		5. Social Security Nur		ex 7. Ag X M 2□F	e (In yrs.	last birthday)	If Under Months		If Under a	24 Hrs. Min.	8. Date of Bir	th V Year			lace (State or Foreign
	Director		245-64-98	95	EZIM ZLIF		61 Yrs.	Months	Days	110013	141111.	06/29/	1941	3	OOU!	NC
	pud		Usual Residence of D 10a, State	Decedent 10b. County		10c Cit	y, Town or Lo	nation							- 14	04 1-14-07-11-2
	sho	5			1 1											0d. Inside City Limits 1 ☐ Yes 2 📉 No
	he N	ect	MD 10e. Street and Numb	Anne Ar	unael	GI	en Bur								į	
	with a or	급	1036 6th					10f. Zip	1060	١			10g. Ci	itizen of Wh	at Coun	itry?
	s 23	era		Delect	12. Was Decedent	Cups in 11	6 12 1				-: 0 (0-		T	USA		
	ter de item	Ë	11. Marital Status 1	d 2□ Married	Armed Forces?		.5.	f Yes, spec	of Hi	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Black,	White,	
36	irs af	by F	3 ☐ Widowed 4		If Yes, Give Year or Dates:	10		1□ Yes 2	2 XX V0	Specify:				Specify:	Wh	ite
Ö	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show ite Madical Exercities Castled at	Completed by Funeral Director	1	5. Decedent's Ed	ducation		16a. Deced	ient's Usua	I Occupa	ation			16b k	(ind of Busi	ness/lnc	fustry
715	n n	ple	(Specify Elementary/Second	only highest gra			16a. Deced (Give life. L	kind of wor DO NOT us	k done d e retired,	furing most	of worki	ng				ercial
212	d with	E	12	Jaly (0-12)	College (1-4or 5	0+)	Refu	eler						Corpor	ati	on
Þ	be filed within 72 ho ital Hygiene. id other than "natui event, Irie Miculcal	BeC	17. Father's Name (F	irst, Middle, Last)						18. Mothe	r's Name	(First, Middle,	, Maidei	n Sumame)		
<u>la</u> r	thould be ad Mental marked o	To E	Jesse Slo	oan Gric	е					Harr	iet	Geno1a	В1г	ickwe1	.der	
Maryland 21215-0036	Pages 1 and 2 should be ment of Health and Mentsent: If item 27 is marked lury or other treumatice		19a. Informant's Nam	ne/Relationship (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	er, City	or Town, St	ate, Zip	Code)
	and 2 alth 27 i		Mr. Kenne	eth Gric	e / Brothe	er	1060	l Gle	n Ha	nnah	Driv	re, Lau	rel,	MD	2072	23
Baltimore,	of He item		20a. Method of Dispo		D	20b. P	lace of Dispo- emetery, cren	sition (Nam	ne of ther place	9)	D	ate	20c. L	ocation - C	ty or To	wn, State
Ĕ	Page nent ent: H		1 □ Bunat 2 1 □ Bunat 2 □ B		Removal from State y)	1	esapea				05/0	04/2005	St	evens	vil:	le, MD
a	# # # # # #		21. Signature of Fund	eral Service Licer	see /	1	22	. Name and	d Addres	s of Facility	Sir	gleton	Fur	neral	Home	e, PA
m	Depril Impo		Mucu	telle A	- COOKIL	M014	15 1	Seco	nd A	venue	SW,	Glen :	Burr	nie, M	ID 2	21061
			23a. Part1. Enter the shock, or heart	disease, or com	plications that caused one cause on each lin	the death	n. Do not ente	er the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Fi		Met	asto	tic	i i		e c					1	Onset and Death
	/Medical		resulting in death)		Due to (or as	a conseq	uence of):	1070	0		0017				(011103
L	Examiner		Sequentially list cond	litions	b											
	. α =	ner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	lediate ving	Due to (or as	a consequ	uence of):									
V	acute ind trans	Examiner	that initiated events resulting in death) La		C											
760,	ate be executed hysician and he burial-transit	û	rosoning in doath, La	31	Due to (or as	a consequ	uence of):									
876	ate b	dicai		•	d											
x 68	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE:													
Вох	ath c	lan/	23b. Was decedent p in the past 12 m		23c. If yes, outcome 1 Live birth	2 Fetal	death 3	Ectopic pre						23d. Date of Month		ry Day Year
o.	0 0 0	ysic	1 Yes 2 1 9 Unknown		4∏Pregnant at 9☐ Unknown	time of de	eath 5	Other (spe	ecify)							July Four
<u>α</u>	that the de led by the a detached		Part II. Other signific	ant conditions o	ontributing to death b	ut not resu	ulting in the up	darking on	use awa	o in Part I		23a Did to	abacco i	usa contribu	ito to the	e cause of death?
ds,	es De	l by			om being to count b	ut 110t 100t	211119 111 1110 111	identying co	iuse give	ii ii i i asti.			/es 2			ably 4 Unknown
Ö	w requir been si should	ete														
of Vital Record	e la has	ompleted										24a. Was autop	SV	pric	ir to com	sy findings available apletion of cause of
E		Ö										1 ☐ Yes	rmed? 2 X No	dea	Yes :	2 🗆 No
Z:	Physicien: Th this certificate ral director, pag	Be	25. Was case referred examiner?	1	Hospital:						of Death	Check only o	ne)			
o	Phys this al dir	L.	1 Yes 2 No	D	1 Inpatie		ER/Outpatient			4 🗀 NUI		ne 5 Resid			Specify,)
	ing Viter	lon	1 Natural	5 Pending	(Month, Day	Year)	28b. Time of Injury	M 28	Bc. Injury Work	?		!8d. Describe h	now injui	ry occurred		
至	r Attending er death. rector: After by the fune	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be		** *-				es 2 N		100 1 11 15				
Division	or A after Direction by	Certification;	4 Homicide	determined	28e. Place of Inju- building, etc	Specify	nne, iarm, stre	et, factory,	опісе		4	City or Tow			or Hurai	Route Number,
1	ne Hospitel or Attendi 24 hours after death ne Funerel Director: A lletely filled in by the fr		29a. Certifier 1,	Certifying Ph	ysician: To the best of	of my kee	wledge death	Occurred :	it the time	a data and	I plane	and due to the	anues'	\ and =	04.65 -1	stad
	24 h	edical	(Check only 2 one)	Medical Exam	niner: On the basis of and manner sta	examinat	tion and/or inv	estigation,	in my opi	inion, death	n occurre	ed at the time,	date and	d place, and	due to	the cause(s)
	To the within 2. To the complet	Me	29b. Signature and tit	le of certifier				29c.	License	number			29d. Da	te signed (/	Month, D	Day, Year)
}	->-0			nue	M.D				+	7574	113			5-03		
	,		30. Name and addres			eath (Item	23a) (Type 1	Print)	<i>y</i>	345	(1)			- 05		>
	P		Young	J00	Lee	300	1 5.	Han	ove	R 51	E	Baltin	nor	e n	nD	21225
	Sta	te	31. Date filed (Month)	Day, Year)	32. Belgistra	ar's Signa										
	Registr	ar	MA	TY 0 5 21	005	ر ریما	K A	4								

		•	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F		lental Hygier	Z U U O	15233
	Physici		Decedent's Name (First, Middle, III)	Last)	REEN			2. Date of Death	Day Year 3 2005	3. Time of Death
	/Medio		4a. Facility Name (If not institution,	give street and number,		4b. City, Town, o	or Location of Death		4c. County of Death	1
	Zami		Union Memoria	l Hospital		Ba	Itimore If Under 24 Hrs.		NA	
	Funeral Director		5. Social Security Number 6 216-09-5389	. Sex 7. A	ge (In yrs. last birthday, 90 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 10-12-	ar) 9. Birthy Coul	place (State or Foreign s.C.
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				Od. Inside City Limits
	Aaryla sho	ō		T 70						1√2 Yes 2 □ No
	28a-1	Director	10e, Street and Number	NA	Ba.	ltimore 10f. Zip Code		10a.	Citizen of What Cou	
	3a or		2009 Boone Str	reet		2121	8		USA	•
36	d within 72 hours after death with the Maryland jiene. I than "natural", or items 23a or 28a-f show I'ra Madical Exterimetr wat be molified at	y Funeral	11. Marital Status 1 Never Married	If Yes, Give	No	Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
Ö	hours tural',	ed by	3 Widowed 4 Divorced 15. Decedent's	Year or Dates:		edent's Usual Occur	nation	166	1	
21215-0036	in 72 n "nal	Completed	(Specify only highest	grade completed)	(Give		during most of work	ing	. Kind of Business/In	dustry
212	d within plene. r than "	шо	Elementary/Secondary (0-12)	College (1-4or		il Handle	r		SX	
P P	be filed ital Hygi id other event, I	Be C	17. Father's Name (First, Middle, La	ist)			18. Mother's Name	(First, Middle, Maid	len Sumame)	
ylaı	should be to the Mental I marked or umatic eve	To	Levi		Green		Irma	cun	Known	
Maryland		0.0	19a. Informant's Name/Relationship Ernestine Green					al Route Number, Cit		
	1 and 2 Health Iem 27 i		20a. Method of Disposition	n wile	20b. Place of Disp			Baltimore,	Md. 212 Location - City or To	
Jor	ages nt of h :: If ite		X Burial 2 ☐ Cremation 3		cemetery, cre	matory or other pla Hill Cem.	_{се)} 5-7-(
Baltimore,	rtme rtant		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Li	· //-		2. Name and Addre				1 Co., Md.
Ва	permit. Pages 1 a Dep-riment of He Important: if Item any injury or oths) to come	Hen		March F.			North Av	21202 e.
	-		23a. Part1. Enter the disease, or conshock, or heart failure. List or	emplications that cause	ed the death. Do not en	iter the mode of dyi	ng, such as cardiac			Approximate Interval Between
里	Physician	2 1	Immediate Cause (Final disease or condition	Tscl	emic B	sample.				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):		000			20093
	LAGIIIIIGI		Sequentially list conditions,	b. AC	ute Ken	al Fa	lure			3 days
_	ted 1sit	niner	cause. Enter Underlying Cause (Disease or injury	Cuia to (or a	s a consequence of)					0
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):				_	
8760,	e be e /siciar e buri	dicai E		d.						
9	tificate ng physi as the	Medi								
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnanc	v		23d. Date of delive	*
	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown	at time of death 5	Other (specify)	-		Month	Day Year
P.0	that the		Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause or	ven in Part I	23e. Did tohaco	o use contribute to t	ne cause of death?
ecords,	sign d be	ed by				underlying dadab gr		1 🗆 Yes		17
006	e law requ has been je 2 shoul	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
$\mathbf{\alpha}$		mo						performed	death?	2 No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					n (Check only one)		
of \	Physic this c	P	1 ☐ Yes 2 No	Hospital: 12 Inpat				me 5 Residence		y)
nc On	E E	lon;	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year) 28b. Time (Injury	Wa	ryat rk?]Yes 2 □ No	28d. Describe how is	njury occurred	
Division	Attendideath, ctor: A y the fu	licat	2 Accident investiga 3 Suicide 6 Could no	t be	njury - At home, farm, s			28f. Location (Street	and Number or Rura	al Route Number
Οį	al or A	Certification;	4 Homicide determin	building, e	etc. (Specify)	oot, iddiory, onioo		City or Town, Si	ate)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: Afte completely filled in by the fune	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	t of my knowledge, dea of examination and/or is stated.	th occurred at the tinvestigation, in my	ime, date and place, opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier			29c. Licen	se number	29d.	Date signed (Month,	Day, Year)
			J. Loran	n- Shan	mo.	AT	2428940		May 3, 20	05
	all		30. Name and address of person w		d with (Item 23a) (Type	, Print)	- דייט לדו	tal of Bo	1	- Vi
	118		Yuanjue L		homa. Un	ion Memo	rial Hospin	tal of Bo	utimore	
	Sta Regist		31. Date filed (Month, Day, Year)		trar's Signature	all I	,			

			For State Registrar	State of Marylan	•	irtment of F		d Mental H	ygiene Reg. No	2000	15234
	ာ		Decedent's Name (First, Middle, Last)					2. Date of I			3. Time of Death
	Physicia /Medic		Wilmer Howard	l Horn				May	4	2005	3:30A M
}	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, o	r Location of D	Death	40	. County of Death	
			116 Hanover Road				erstown			Balt:	
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, I	Day, Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	13				Aug. 2	1,192	29	MD
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	a Mar	tor	MD Baltimor	e	Reist	erstown					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Cou	ntry?
	23a		116 Hanover Road				1136			USA	
	ar de.	Funerai	Tr. Maritar States	. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Vas Decedent of H f Yes, specify Cub	lispanic Origin an, Mexican, P	? (Specify Yes or I uerto Rican, etc.)	No-	14. Race - Americ Black, White,	
36	rs aft	by F	1 Never Married 2X Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:		□ Yes 2X No	Specify:			Specify:	
9	tural		15. Decedent's Educa	ation	16a. Deced	lent's Usual Occur	pation		16b. K	Whi	
715	nin 72 n "n Nedik	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of	f working	100,11		
212	d with	E	12	College (1-401 5+)	Se	curity G	uard			РНА	
9	al Hy l othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd	le, Maider	Sumame)	
<u> a</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is markad other than "natural; or Itams 23a or 28a-f show aumatic event, the Medical Era⊤iret must be nutilied at	To	Wilmer Horn				Ma	ary Cole			
Maryland 21215-0036	2 sh and ia m	0 }	19a. Informant's Name/Relationship (Type	e, Print)	1			or Rural Route Num			•
	1 and 4ealth 9m 27 ther t		Regina K. Horn	Wife		Hanover sition (Name of	Road, R	Reisterst Date	1		
Baltimore,	Pages 1 nent of H ant: if ite		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Rei		emetery, cren	natory or other pla	ce)	Date	20c. L	ocation - City or To	own, State
Ē	t. Pa rtmen rtant: njury		' 4 □ Donation 5 □ Other (Specify)			Cremation	400	5/5/05		mpstead,	
Bal	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	PA	- 1	. Name and Addre	•			eistersto	
			23a. Part1. Enter the disease, or compile	ations that caused the deat		ine Fune				stown, MD	Approximate
		9	shock, or heart failure. List only one	cause on each line.			-	retion			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a conseq		SYGIAL	m19	Ac Lion	1		minuth
	Examiner			Dao 10 (01 23 2 0011384	derice or).						
,		Je.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a conseq	uence of):						
1	icate be executed physicien and s the burial-transit	Examiner	that initiated eventsc.								
o,	e exe ien al urial-t	EX	resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	ate b hysic the bu	dicai	d.								
9	eath certific attending p	0	IF FEMALE:					P. 11. 11. 11. 11.			
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3□	Ectopic pregnanc	у			23d. Date of delive Month	ery Day Year
0	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□ Unknown	eath 5∟	Other (specify) _	-				,
<u>α</u>	that the de ed by the detached	Ph	Part II. Other significant conditions conti	ributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Dio	i tobacco	use contribute to t	he cause of death?
ds,	uires tha signed Id be del	d by						1 [Yes 2	Mo 3□Prot	pably 4 Unknown
COL	w requir been si should	ete						24a. Wa	as an	24h Were auto	psy findings available
Be E	he lav e has age 2	Completed						aut	topsy rformed2	prior to co death?	mpletion of cause of
Vital Records,	ician: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of	1 ☐ Yes	$-\omega$	1 Yes	2 LJ No
	ysicia is cert direct	0 0	examiner?	spital:	ER/Outpatien	t 3 DOA Ott		ng Home 5 × He		6 ☐Other (Specif	(v)
0	g Ph	ı. T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui	ry at	28d. Describ			,,
Ö	auth. or: Af	atic	1 Accident 5 Pending investigation	(Month, Day 1 day	iiijaiy		Yes 2 □ No				
Division of	r Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location City or 7	(Street ar	nd Number or Rura e)	al Route Number,
Ω	itat o irs afi ral Di			h l				hin			
	Hosp 24 hor Fune tely fi	Medicai	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examine	cien: To the best of my kno er: On the basis of examina	wledge, death tion and/or inv	noccurred at the tile restigation, in my control	me, date and p pinion, death o	place, and due to the concourred at the time	e cause(s e, date an) and manner as s d place, and due to	tated. o the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Mec	29b. Signature and title of certifier)	and manner stated.		29c. Licens	se number		29d. Da	ite signed (Month,	Day, Year)
	⊬ 3 - ŏ		Valuat of	and one		V	1327	12		5 U. a	_
			30. Name and address of person who com	pleted cause of death (Iten	n 23a) (Tvne	Print)			L		
	611			oney, MD	Suite	403,70	505 Os	ler Mi	Je 7	Tow son	Mysisch
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa							
	Registi	rar	MAY 0 5 200	5 Page	K A	100					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2, 2005 **Physician** Year Alfred E. 3:05 p **Iwantsch** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Austria **Funeral** 1 → M 2 □ F Yrs. Director 213-26-3843 75 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Meryland Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21152 23 Rainflower Path Unit 204 1150 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Š 3 ☐ Widowed 4 X Divorced lihi te Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physician Medicine s 1 and 2 should be filed w f Health and Mental Hygier item 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hermine Edmund **Luantsch** Graf 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 I 18 Abbey Bridge Court Timonium, Maryland 21093 Elizabeth A. Keller / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5/6/05 Towson, Maryland 21. Signature / Fun. 11 Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 CZ angy! 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYEL ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 XNo ို this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: the Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled in 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

A-FRED

Ó

50

3

graf

State Registra

29b. Signatule and title of certifier

DR. TARIGE MAHMOOD, 2300 DULANGY VALLEY ROAD, TIMONIUM 32. Registrar's Signature 31. Date filed (Month, Steen & Good

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

2005

5/3

	1	For State Registrar	State	of Marylan		artment of F			giene.	15	152	36
		1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath Day	Year	3. Time of I	Death
Physicia /Medic		Jane		Theres	е	In	gwersen	May	3 20		1:30	a ^M
Examin		4a. Facility Name (If not institution	n, give street and i	number)		4b. City, Town, o	r Location of Deat	h	4c. County	of Death		
		312 Pytchley	Run Road			Annap	olis		Anne	Aru	nde1	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h (Year)	9. Birthp	place (State or	Foreign
Director		INK	1□ M 200	7	6 Yrs.	Months Days	7,00.0	Dec. 17			Jersey	<i>r</i>
P		Usual Residence of Decedent		10- Ci	ty, Town or Lo						tOd Inside Cit	. f. i and a
aryla ehov	_	10a. State 10b. County									10d. Inside City 1 ☐ Yes	
Ba-f	cto		Arundel		Annapo.							
or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?	
ath w	<u>ra</u>	312 Pytchley					21403			SA		
ar de tams	Funeral	11. Marital Status	Armed	ecedent Ever in U Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	ipecify Yes or No- to Rican, etc.)	Blac	e - Ameno k, White,	can Indian, etc.	
s afte	by F	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	It Yes.	s 2 🛣 No Give r Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify	r:	White	
hour In			nt's Education	Dales.	16a Dece	dent's Usual Occup	nation		16b. Kind of Bu	icinace/In	duetne	
n 72	Completed	(Specify only higher	st grade complete		(Give	kind of work done DO NOT use retire	during most of wo	rking	TOD. KING OF BC	13111033/111	loustry	
withi ena. than	Ĕ	Elementary/Secondary (0-12)	College	9 (1-4or 5+) 2	Human	n Resourc	es		Stewar	t En	terpris	es
If a rail of the Maryland filed within 72 hours after death with the Maryland Hygiena.	Ö -	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	me (First, Middle,				
d ba antal cad o	00	Vincent Moyla	n				Phv11	is Rice				
Idf yidfild ZIZIS-00000 2 should be filed within 72 hours after death with the Marylan and Mental Hygiens is marked other than "natural", or itams 23a or 28a-f ehow aumatic event. If a Modical Examination and the notified at	၉	19a. Informant's Name/Relations			19b. Maili	ng Address (Street			r, City or Town,	State, Zir	Code)	
d 2 s d 2 s th an th an trau		Gene A. Ingwe		shand)		Pytchley						
Heal Heal		20a. Method of Disposition	Iben (na.	20b. F	Place of Dispo	sition (Name of	1	Date	20c. Location -			
rmit. Pagas spartment of portant: if it y injury or o		1 K Burial 2 Cremation		m State	•	natory or other pla		2005	D	1) (D	
it. P. strand ritani		* 4 □ Donation 5 □ Other (S		Ft		oln Cemet 2. Name and Addre		-2005	Brentw	30a,	MD	
paritimote, individual yiditu Zizipermit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: if Item 27 is marked other than any injury or other traumatic event. Ite Magnee.		2 · 2 · (X.		-	Hardesty	Funeral	Home, P	.A.		103	
		23a. Part1. Enter the disease, or	mplications the	at caused the deat	th. Do not en		ly Avenu			0 214	401 Approximate	
		shock, or heart failure. List	only one cause o	n each line.	To not on			o or respiratory at	1031,		Interval Betw Onset and D	reen
Physician		Immediate Cause (Final disease or condition resulting in death)	a	nelas	lake	n Ca	ince					
/Medical Examiner			Due	to (or as a consec	quence of):	0.						
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	to (or as a consec	auence at	Can	-61			-		
lsit ed	lner	cause. Enter Underlying Cause (Disease or injury	< − 3.0	10 (01 40 4 001100	100,100 311.							
and and II-trar	Exam	that initiated events resulting in death) Last	c	to (or as a consec	quence of):							
cate be exacuted physician and the burial-transit	a E											
cate phys	dlcal		d									
h.C. box 661 that the death certificate ed by the attending phys detachad for use as the	hystcian/Me	IF FEMALE:	23c. If ves	outcome of pregn	ancv				22d Day	e of delive	00/	
death c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	re birth 2 ☐ Feta	al death 3	Ectopic pregnancy Other (specify)	у		Moi			ear
the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		known	Jeau J	Ottlet (specify)						
that the	Q.	Part II. Other significant conditi	ons contributing to	o death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use conti	ibute to t	he cause of de	eath?
v 8 2 2	d by							18	es 2 No	3 ☐ Prot	oably 4 🗆 U	nknown
w requir been si should	ompleted							04- 146-		AZ		
AL CO VICI	du							24a. Was autop perfor	sy 290. V	rvere auto prior to co death?	ppsy findings a mpletion of ca	use of
ate Th	Ö									Yes	2 No	
Of VICAL Physician: The Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Heenitel			Ott	200	ath (Check only o				
this aldid	5	1 Yes 2 No		-	ER/Outpatie	II 3LI DOA		dome 5 Resid			(y)	
ing ing	Certification:	27. Mann of Death 1	ng (M	ate of Injury fonth, Day Year)	28b. Time of Injury	Wo	rk?]Yes 2 □No	Zod. Describe i	ow injury occurr	BU		
DIVISION of a for Attending Is after death. I Director: After d in by the funer	cat	2 Accident investi 3 Suicide 6 Could	not be	and Jaimes At h			1182 5 1140	20f Longtion /6	Street and Numb	or or Pum	I Pauto Mumb	205
	ertif	4 Homicide determ	nined 289. Fi	rilding, etc. (Speci	fy)	reet, factory, office		City or Tow		si Oi Figie	ar House reamb	61,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifyi	na Physician: T-	the heat of!	outodes de-	h aggregat of the c	mo data and size	and due to the	auea/al and	nner s	tatad	
Hos 24 ho Fun fely f	edical	(Check only 2 Medical one)	I Examiner: On the	the best of my kno e basis of examina nanner stated.	ation and/or in	h occurred at the till vestigation, in my o	opinion, death occu	urred at the time,	date and place, a	and due to	o the cause(s)	
To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifie		stateu.		29c. Licens	se number		29d. Date signed	(Month.	Day, Year)	
E .₹ 8		1	1/		Test	n Ar	3306		=/	11.	7	
		20 11-20	· WK	un de de de de de	-03016	Print))/;	110	/	
6		30. Name and address of person	who completed c	ause of death (Ite.	III 23a) (Type,	Print) Rel Ste	ap 7 11	Knin an	1.0	1	1 9 ///	- 14
Sta		31. Date filed (Month, Day, Year	32	2. Registrar's Sign	547C	101 216	F// (THE REPL	11/2	011	1-146	
Regist			5 2005	Elseus	J. A	perke						

			For State	State of Maryland / Dep	partment of He		, ,	0.0.	
	Dharaisi		Registrer 1. Decedent's Name (First, Middle, Last)		Timodio of D		2. Date of Death Month	g. No.	3. Time of Death
	Physici /Medic	al	Laura Y. Johnson		1 Cir. T		April 2	3, 2005	7:51 P M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give s Holy Cross Hospita 5. Social Security Number 404-64-4670	1		ring If Under 24 Hrs.	8. Date of Birth (Month, Day, Feb. 24	Montgomery Year) 9 Birth Cou 1912 Alal	place (State or Foreign
	B		Usual Residence of Decedent				TCD: 24		
	farylar show	o.	10a. State 10b. County	10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 📆 No
	r 28a-f	Director	Maryland Montgomer 10e. Street and Number	y Silver Sp	10f. Zip Code		10	g. Citizen of What Cou	
	th with		11303 Cloverhill D	rive	20902		U	nited State	es
920	perrilt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	l. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☒ No	panic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036	within 72 hound. Ind. "naturitie Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) 16a. Dec (Giv life. College (1-4or 5+) Homem	edent's Usual Occupations with done dure the book of work done dure DO NOT use retired)	on ring most of working	g	6b. Kind of Business/Ir	
Q 2	Hygie other ent,	Be Co	17. Father's Name (First, Middle, Last)	nomen		8. Mother's Name (wn Home aiden Sumame)	
/lan	Mental Mental arked	To B	Joe Yelder			Larsenia	Moultr	ie	
/au	l 2 sho l and l ls me		19a. Informant's Name/Relationship (Typ	The state of the s	ling Address (Street and				Code)
ē,	1 and Healt tem 2		Edith Childress/Da 20a. Method of Disposition		Box 148,			1543 Oc. Location - City or To	own, State
altimore,	Pages nent of nt; If i		1 Burial 2 ☐ Cremation 3 ☐ Re 1 Donation 5 ☐ Other (Specify)	emoval from State Mt. View Memory G	position (Name of ematory or other place) landens	Apr 30.	2005 H	uddy, KY	
Balti	epartm sporte ny inju		21. Signature of Funeral Service License	000001	Pare and Address Hatfield		THE RESERVE AND ADDRESS OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS N		
	205 29		23a Part Enter the grace of amelic	Destine that caused the death. Do not on				r, KY 41514	
k	Physician		23a. Part1. Enter the disease, of complic shock, or heart adure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	men me mode of dying,	Suci as cardiac or	respiratory arres	51,	Approximate Interval Between Onset and Death days
	/Medical Examiner		reserving in assum,	Due to (or as a consequence of):					3evm
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):					
V	icate be executed physician and s the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	·				
8760,	e be existian sician buria	dicai E	d						
9	rtificat ng phy s as th	Medi	IF FEMALE:						
P.O. Box	The law requires that the death certific tle has been signed by the atlending p tage 2 should be delached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
	res that igned b be deta	by Pl	Part II. Other significant conditions con		underlying cause given	in Part I.	23e. Did toba	icco use contribute to t	he cause of death?
ord	w require been si should t	ted	Peripheral Vascula	r Disease			1 Tes	2 X No 3 □ Prot	pably 4 □Unknown
al Records,		Completed	Cardiomyopathy				24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
Ž		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ospital: 1 Inpatient 2 XER/Outpatie	Othor	26. Place of Death) ice 6 ☐Other (Specif	
Division of Vital	ding After fune	\vdash	27. Manner of Death 1 X Natural 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?		3d. Describe how		97
Divis		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28	3f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier X Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, dea er: On the basis of examination and/or i and manner stated.	nvestigation, in my opin	nion, death occurred	at the time, dat	e and place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License n	number	290	d. Date signed (Month,	Day, Year)
	= 1		30. Name and address of person who con	Tipleted cause of death (Itam 22a) /Time	D 32	2332	A	pril 25, 20	005
	4		S.K. Gupta, MD	9801 Georgia Ave.		, Silver	Spring.	MD 20902	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 200	32. Aegistrar's Signature					

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 005 5238
	Physic		1. Decedent's Name (First, Middle, Last) CLIFFORD LEE JAMES, SR. 2. Date of Death Month Month Day Year 15:/3 M
) 	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or location of Death ALTIMOLE N/A 5. Social Security Number 217-12-0042 4c. County of Death N/A 1
poolo	thow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits
the the Most	a or 28a-f a	Funeral Director	MarylandBaltimoreRelay1 □ Yes 2 ₺ №10e. Street and Number10f. Zip Code10g. Citizen of What Country?5004 Maple Avenue21227USA
1215-0036	half Hygiene. Na Hygiene. Ad other than "natural", or Items 23a or 28a-f show avant, I're Madical Examination or still be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Married 3 Married 3 Married 4 Divorced 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No Specify: White
21215-0036	jiene. r than "natura	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Technician 16b. Kind of Business/Industry Westinghouse Corp.
/land	snould be med withing and Mental Hygiene. s markad other than umatic avant, Ire M	To Be C	17. Father's Name (First, Middle, Last) Joseph James 18. Mother's Name (First, Middle, Maiden Surname) Catherine Hayes
e, Mar	if Health and Meritam 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford L. James, Jr. (SON) 5004 Maple Ave., Baltimore, Md. 21227 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State)
Baltimore,	nent o		1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 5/6/05 Baltimore, Maryland
Р	hysician /Medical ixaminer	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset a
O. Box	by the attending p	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Month Day Year
Records, P	been signed t	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chrons
al Reco		Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1
Division of Vital	fler death. Director: After this in by the funeral dii	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No
Hospite	within 24 hours a To tha Funaral C completely filled	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To tha	within To th comp	Me	29b. Signature and title of certified Dio 27315 May 3, 2005
	ラド Ste	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Fryden Stry MD 31. Date filed (Month, Day, Year) 32. Registrar's Signaylre
DHMH	Registr	ar	MAY 0 5 2005 Some State

				Department of Health Certificate of Death	and Mental Hygi	
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medi		CORNELIA B. KEELS		MAY	4, 2005 6 A M
	Examir	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location	n of Death	4c. County of Death
	Funeral		GOOD SAMARITAN NURSING CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last bi		er 24 Hrs. 8. Date of Birth	N/A 9. Birthplace (State or Foreign
	Director	1	247 96 5061 1 □ M 2 🖫 100 Usual Residence of Decedent	Yrs. Months Days Hours	Min. (Month, Day,	Country) 19045. CAROLINA
	inylan ihow	_	10a. State 10b. County 10c. City, Tov	wn or Location		10d. Inside City Limits
	ath with the Marylar 123a or 28a-f show ust be notithed at	cto	MD N/A BALTIM	ORE		1X Yes 2 No
	with the	Dice	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
	eath	eral	1601 BELVEDERE AVE. 11. Marital Status 12. Was Decedent Ever in U.S.	21239		J.S.A. 14. Race - American Indian.
920	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23a or 28a-f show evant. If a Medical Evarifier russi be rotified at	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexico 1 ☐ Yes 2 1 No Specify		Black, White, etc. Specify: BLACK
21215-0036	in 72 ho n "natur ledical	Completed	(Specify only highest grade completed)	(Give kind of work done during mo life. DO NOT use retired)	ost of working	Sb. Kind of Business/Industry
212	d within glene. ar than "	mo	Elementary/Secondary (0-12) College (1-4or 5+) 9th FAI	RMER WORKER	SI	ELF EMPLOYED
	be filed ital Hygi id other	Be	17. Father's Name (First, Middle, Last)	18. Moti	her's Name (First, Middle, Ma	
yla	should be nd Mental marked	2	BRUTUS NELSON	CATH	HERINE BROWN	
, Maryland	alth ar 27 Is r trau		ANNIE L. WALLACE (DAUGHTER) 31	b. Mailing Address (Street and Number L32 HARFORD ROAD		
Baltimore,	Pages 1 a nent of Hea int: If itam iry or othe		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of ery, crematory or other place)		Oc. Location - City or Town, State
Ħ	# 문문를		. 4 □ Donation 5 □ Other (Specify) CEDAR 21. Signature of Fugeral Service decease	22. Name and Address of Faci		BALTIMORE, MARYLAND SCRUGGS FUNERAL HOME
Ba	Depa Impo any is		1 Carried			MORE, MARYLAND 21213
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	lia	is cardiac or respiratory arres	t, Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence d.			
Box 68	The law requires that the death certifics ate has been signed by the attending pt page 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death			23d. Date of delivery Month Day Year
P.O.	the de	hysic	1 ☐ Yes 2 No 4☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting i	in the underlying cause given in Part		cco use contribute to the cause of death?
Records,	The law re ite has bee	Completed			24a. Was an autopsy performe 1 Yes 20	24b. Were autopsy findings available prior to completion of cause of death? ↑ No 1 □ Yes 2 ♠ No
Vital	stan: artifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Plac	ce of Death (Check only one)	7140 12165 42010
ot O	hysic his ce I dire	To E	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Ou	utpatient 3 DOA Other: N	lursing Home 5 🗆 Residen	⇒ 6 □Other (Specify)
D C	Attanding Physician: r death. actor: After this certifics by the funeral director, i			Time of 28c. Injury at Injury Work?	28d. Describe how	injury occurred
Sio	ttandi death. ctor: A / the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐		
Division	after of Dirac	Certification:	4 Homicide determined 28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, factory, office	City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge and manner stated.	e, death occurred at the time, date a nd/or investigation, in my opinion, de	and place, and due to the cause eath occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	29c. License number	290	Date signed (Month, Day, Year)
	H		30. Name and address of person who completed cause of death (Item 23a) 560 Loch Raveur Buy	(Type, Print) Ballini	ore, red	- 21239
	Sta	_	31. Date filed (Month, Day, Year) MAY 0 5 2005 32. Refistrar's Signature.			1
	Registr	ar	MIHI O D COOD	1		

		1	For State Registrar		State of	Marylaı		artmen rtificate			and M	lental Hy	gien Reg. No	2005	152	1,0
//	ysicia Vedica	n al	1. Decedent's Name (First, Midda Thomas		James		Kenned	_				2. Date of De Month May	aath 1	2005	3. Time of 3:00	
	eral		4a. Facility Nam <i>e (If not institutio</i> 5660 Battee] 5. Social Søcurity Numbør	Oriv 6. Søx	e 7.		. last birthday)	Chu If Under	rcht 1 Year	If Under	24 Hrs.	8. Date of Bir	rth	Anne Arui 9. Birth		or Foreign
Dire	ctor	-	216-58-6127 Usual Residence of Decedent 10a. State 10b. County		M 2 F	5. 10c. C	Yrs.	Months	Days	Hours	Min.	Sept.	12,	1951 Wasi	ningtor	n, DC
th the Mary or 28a-t ah	e rottibed	Director	MD Anne 10e. Street and Number	Aru	ndel		Churcht	On 10f. Zip	Code				10g. Ci	tizen of What Cou	1 □ Yes	-171
ire, Maryland 21215-0036 s 1 and 2 should be tiled within 72 hours after death with the Maryland f Health and Mental Hygiene. itam 27 is marked other than "natural", or Itams 23a or 28a-1 ahow	d Examples mast b	by Funeral	5660 Battee Dr: 11. Marital Status 1 Never Married XXMar 3 Widowed 4 Divorced	ied 1	2. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	∌s? ∑ No		Was Deced f Yes, spec		spanic Orig n, Mexican	gin? (Spe , Puerto l	ocify Yes or No Rican, etc.))-	USA 14. Race - Ameri Black, White, Specify:		
Maryland 21215-0036 d 2 should be tiled within 72 hours af th and Mental Hygiene. 77 is marked other than "natural", or	The Medica	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Educ st grade	ation completed) College (1-4- 4	or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done di	urina most	of workii	ng		and of Business/Ir		
aryland should be tile and Mental Hy markad oth	matic avant	10 Be	17. Father's Name (First, Middle, Thomas J. Kenne 19a. Informant's Name/Relations	dy,			19h Mailie	ag Addrage		Elai	ine ((First, Middle) Godtfri	ng	n Sumame) or Town, State, Zij		
attimore, Ma rmit. Pages 1 and 2 s partment of Health an portant: It itam 27 is.	or other trau		Charlotte Kenne 20a. Method of Disposition 1 □ Burial 2XX remation	dy	(Wife)	ite (5660 Place of Dispo	Batte sition (Nam natory or ot	e Dr e of her place	ive,	Chur	chton,	MD			
Baltimor	any injury once.		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		7	Met	ro Cre	Name and Hard	Address esty	of Facility Fune	eral	Home,	P.A.	imore, M		
8760, Aretuled Bxam Impact Impact	ical ner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b.	Due to (or	as a consectant as a consec	quence of):	er the mode	of dying	lla liac	turi	r respiratory and	rrest,		Approximate Interval Betw Onset and D	veen)eath
. Box 68 death certitica e attending ph	= 1	M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 ☐ Feta at time of d	uldeath 3□	Ectopic pre						23d. Date of delive Month		'ear
th:	pe i	ີລ ໌	Part II. Other significant condition	les Contr	ibuting to death	but not res	ulting in the ur	iderlying ca	use giver	in Part I.		23e. Did to		use contribute to the	ne cause of de	
The The	page 2		25. Was case referred to medical									1 ☐ Yes	rmed? 2 No	death?	mpletion of ca	vailable use of
n OT ng Phy fter this			examiner? 1 Yes 2 No 27. Manner of Déath 1 Matural 5 Pendin 2 Accident investig 3 Suicide 6 Could	Ho g jation		njury Day Year)	ER/Outpatient 28b. Time of Injury	28 M	Other c. Injury a Work? 1 Ye	4 □ Nur	sing Hom 2i	8d. Describe h	lence now injur			- H
Spital or At cours after of naral Dirac	filled in by) _	4 ☐ Homicide determ	n <i>e</i> d		etc. (Specif	y) 			date and		City or Tow	vn, State	d Number or Rura) and manner as st		er,
DIVISIO To the Hospital or Atlandi within 24 hours after death. To the Funaral Director: A	completely tilled in		29b. Signature and title of certifier	7	and manner	stated.	lion and of my	29c.	License	nion, deatr	occurre	a at the time, t	date and	and manner as st place, and due to signed (Month, I	the cause(s)	
Bo	State		James J. Ben: 31. Date filed (Month, Day, Year)	ami	n, MD 8		itchie		ay,	Pasad	lena,	, MD 21	122			

Amend item#31, per DVR, C843,5705 TT State of Maryland / Department of Health and Mental Hygiene () () 5 15241 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2学片 **Physician** 2005 2250 PM Theresa Kuhn Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner with Armodel to grata Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2XXF 214-56-1228 56 Yrs Director June 8, 1948 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, If a Mudical Examiner must be notified at Glen Burnie 1 Yes XXNo Directo MDAnne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3 Glenmont Avenue items 23a USA Completed by Funeral 21061 be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 X Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Caretaker Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental Henry Wojcik ပ FRances Sczepanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Mary Ann Wallace (Sister) 98 Summerhill Park, Crownsville, MD 21032 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Metro Crematory 5/2/2005 Baltimore, MD 21. Signature of Funeral Service Transee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CARDIO - PULMCHARE **Physician** /Medical Due to (or as a consequence of): ENCEPHALOPA THY **Examiner** HYPOGYLEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine MELLITUS - POUTOU The law requires that the death certificate be executed DIABETES Due to (or as a consequence of): SEIZULES Physician/Medical Вох IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 0 9☐ Unknown 9 Unknown þ ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, by 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes 2 200 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death Check on one examiner's Hospital: 1 Limitent 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ Næ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After tending Division Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation afte death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) EFAIN fung SE. GLEN BURNE ALD 30. Name and address of person whill completed cause of death (Item 23a) (Type, Print) JUALA rus) 1307 MANE HLIF 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

ORIGINAL

			1 - For State Registrar	-		/ Depa		lealth and M Death	ental Hygie	-	5 15242
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Las Aa. Facility Name (If not institution, give Greater Baltimor	ALICE street and number)	M. Cente		4b. City, Town, o	r Location of Death	2. Date of Death Month May	2, 200 4c. County of D Baltin	Death
	Funeral Director		Usual Residence of Decedent	9X □MXXF 7. Age	93	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 12-17-19	(ear) 911	Birthplace (State or Foreign Country) NEW YORK
	death with the Maryland ms 23a or 28a-f show r nust be millited at	rector	MD. BALTIN	10RE	10c. City, T	own or Loca	TIMO	NIUM	100	g. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes XX No t Country?
9	ē # #	/ Funeral Director	2525 POT SPRIN 11. Marital Status 1 Never Married 2 Married	IGS ROAD 12. Was Decedent E Armed Forces? 1 □ Yes 2XX	Ever in U.S.		as Decedent of H 'es, specify Cuba	21093 ispanic Origin? (Spein, Mexican, Puerto I	cify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc.
MICE 21215-0036	vithin 72 hours ne. hen "natural", e Medical Exc	Be Completed by	15. Decedent's Ed (Specify only highest grade)	year or Dates: ucation	1	6a. Decede (Give ki life. Do		ation during most of workir)	ng 16	Specify: Sb. Kind of Busine OWN	WHITE ess/Industry
_ E	ould be filed w Mental Hygie arked other ti etic event, III	To Be Col	12 YEARS 17. Father's Name (First, Middle, Last)	FRANK M I	NILHEL		10025#1F	18. Mother's Name EMMA	(First, Middle, Ma	iden Sumame)	TIONE
	t and 2 sho Health and tem 27 Is m		19a. Informant's Name/Relationship (7 DAVID J. LIPINSK 20a. Method of Disposition		20b. Płace	3106 e of Disposi	SUNSET	LANE, PHO	DENIX, MA		21131
Lip Baltimore	permit. Pages Department of Important: If i any injury or o		XX Burial 2 Cremation 3 Compared to 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens)		WOOD (tory or other place EMETERY Name and Addres CK TOWSO	05-06-	-2005 PA	RKVILLE 1050	, MARYLAND YORK ROAD
•	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (3 as a	75	Do not enter				1003	Approximate Interval Between Onset and Death
8760, <	ite be iysicië	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.			owe	X			(day
P.O. Box 68	Attending Physicien: The law requires that the death certifica rideath. ector: Atter this certificate has been signed by the attending phey the funeral director, page 2 should be detached for use as the funeral director.	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1	2 ☐ Fetal dea	ath 3 □E	ctopic pregnancy ther (specify)			23d. Date of Month	delivery Day Year
ords, P	w requires that been signed b should be deta	ted by PI	Part II. Other significant conditions co	ontributing to death bu	t not resultin	g in the und	erlying cause give	on in Part I.	23e. Did tobac		e to the cause of death? Probably 4 □Unknown
tal Reco	icien: The law r certificate has be rector, page 2 sh	e Comple	AMALE SUM 25. Was case referred to medical	llation	(00 Div. (D. 1)		di? death	autopsy findings available to completion of cause of 1? (es 2 No
Division of Vital Records,	iding Physicien: th. After this certific funeral director,	To B	examiner?	Hospital: Inpatier 28a. Date of Injury (Month, Day		Outpatient b. Time of Injury	3 DOA Other	at 28	e 5 Residence		Specify)
Divisi	tal or Attendir rs after death. al Director: Al ed in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc.	ry - At home (Specify)	, farm, stree			Bf. Location (Stree City or Town, S	at and Number or State)	Rural Route Number,
		edical	29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exam 29b. Signature and title of certifier	sician: To the best or iner: On the basis of and manner stat	examination	dge, death o and/or inves	tigation, in my op	inion, death occurred	d at the time, date	and place, and d	due to the cause(s)
	5 × 0 0	_	30. Name and address of person who co	MP ompleted cause of de	ath (Item 22)	a) (Type Pr	29c. License	428	290.	Date signed (Mo	mui, Day, Tearj
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar	aveau	ter	Baltiv	nove M	ldica	l Cert	ter
	Registra	_	MAY 0 5 21	005	L	Lifered	- A				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrer	State of Maryland /		nt of Health and te of Death		ene . No 2011	5 15017
			Decedent's Name (First, Middle, La	st)			2. Date of Death		3. Time of Death
	Physic		Arthur	Morrison Lynch	n. Sr.		Month	Day Year 200	
	/Medi Exami		4a. Facility Name (If not institution, giv			, Town, or Location of De		4c. County of De	
	=		SINAL HOSPITAL OF	BALTIMORE	B	ALTIMORE		N/A	
	Funeral		5. Social Security Number 6. S	iex 7. Age (In yrs. last b		r 1 Year If Under 24 H			irthplace (State or Foreigr Country)
п	Director		212-01-0124	XM 2□F 99	Yrs. Months	Days Hours Mi	n. (Month, Day, Y APR 30,		aryland
	pu ,		Usual Residence of Decedent 10a, State 10b, County	10.05.7					
	ne Maryla 8a-f shov Alilied at	ctor	Maryland N/A	10c. City, Tov	wn or Location	Baltimore			10d. Inside City Limits 1 XYes 2 □ No
	ith th	Dire	10e. Street and Number			p Code	10g	. Citizen of What C	Country?
	ath w	ľa	2211 West Rogers			21209		USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	13. Was Dece If Yes, spe	dent of Hispanic Origin? ocify Cuban, Mexican, Pue 2 X No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
Ö	2 hou	ed	15. Decedent's E		a. Decedent's Usu	al Occupation	16	b. Kind of Busines	e/Industry
21215-0036	nin 72	Completed	(Specify only highest gra	de completed)	(Give kind of wo	ork done during most of w use retired)	orking	Pretzel	•
212	f with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		nager/Store	_	Concessi	J '
	filled I Hyg othe	Be C	17. Father's Name (First, Middle, Last,		LIICC III		ame (First, Middle, Ma.	den Sumame)	on Stand
a	lld be lenta ked ic ev	To B	James Edward Ly	nch		Flo	rence Loane		
Maryland	shound M	-	19a. Informant's Name/Relationship (b. Mailing Address	s (Street and Number or I			Zip Code)
	nd 2 alith a 27 is r tra		Carolyn E. Bracke			n Avenue Ca			
5	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any njury or other tra once.		20a. Method of Disposition		of Disposition (Na.			. Location - City o	
JUO	age ent of ht: If		1 X Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	JI TOTTO VALLETO III STATE		emetery 5/6	1/05 D	ileografillo	MD
Baltimore,	artme orter njur	1	21. Signature of Funeral Service Licer		22 Name at	nd Address of Facility		ikesville	•
Ba	Department	. 6	Lewist You	sordule	MacNab	b Funeral Ho ederick Road	ome, P.A.	040	•
				gorchik	not enter the mod	ederick Road	Baltimore	, MD 212	28 Approximate
	20.00		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	A		or dying, door as dardi	ac or respiratory arrest		Interval Between Onset and Death
	Pnysician /Medical	i i	disease or condition resulting in death)	a. ATRIAL FIBRILL.					
	Examiner			Due to (or as a consequence	•				S DAYS.
		<u></u>	Sequentially list conditions,	b. ACUTE LOWER I		ISCHEMIA			> 12 '
T	ted nsit	ü	Sequentially list conditions, they leading to find class cause. Enter Underlying Cause (Disease or injury						
v .	ficate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	of):				
8760,	be e	aiE							
687	phys phys the	dicai	== ==	_ d					
	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy					
Вох	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	1 3 □Ectopic po 5 □ Other (sc			23d. Date of de Month	Day Year
o.	the dr	ysic	1 Yes 2 No 9 Unknown	9 Unknown	3 □ Other (st	ecny)			
Q .	that the de led by the de detached	h h	Part II. Other significant conditions of	ontributing to death but not resulting i	in the underlying o	ause given in Part I	23e Did tobac	co use contribute to	o the cause of death?
Vital Records,	signe d be	d by				PT FAILURE	1 ☐ Yes	_	robably 4 Munknown
Ö	w require been sig should b	ete				P. PRIORPO		22.10	Zonkiowi
}ec	e 2 s	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
1		Ö					performed		3 2 □ No
/ita	Physicien: this certificatal director,	Be	25. Was case referred to medical examiner?				ath (Check only one)		
of	Physi this o	6	1 ☐ Yes 2 📉 No	Hospital: 1 Mnpatient 2 ☐ ER/Ou		Other: 4 Nursing	Home 5 Residence	6 □Other (Spe	ocify)
ū	ng fter	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Time of 2 Injury	8c. Injury at Work?	28d. Describe how i	njury occurred	
sio	Attending ir death. ector: After by the funer	cati	2 Accident investigation		M	1 ☐ Yes 2 ☐ No			
Division	tel or Attendi rs after death. el Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory	/, office	28f. Location (Stree City or Town, S	and Number or Ri ate)	ural Route Number,
	To the Hospitel or a within 24 hours after To the Funerel Dire completely filled in b	edicai C	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge niner: On the basis of examination an	e, death occurred	at the time, date and place	e, and due to the cause	e(s) and manner as	s stated.
	the H in 24 the F iplete	edi	0110)	and manner stated.	id/or investigation	, in my opinion, death occ	urred at the time, date	and place, and due	of the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		290	. License number	29d.	Date signed (Mont	h, Day, Year)
)			* nult t	MA		17220	P	AY 3, 20	105
	100		30. Name and address of per on the	completed cause of death (Item 23a)	(Type, Print)		1	,	
	10		WILLIAM REECE BURNS	MD SINAI HOSPITAL O	F BALTIMORE	2401 W. BELVI	EDERE AVE BA	LTIMORE MI	0 21215
	Sta Registr	- 100	31. Date filed (Month, Day, Year)	32. Registrar's Signature	*			AMA	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year ELAINE LEMBACH 9:00a M MABEL MAY 03 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 508 EAST RANDALL STREET 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 24 Maryland **Funeral** 1□M 2 F 216-16-9807 81 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Marvland N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 E. Randall Street Items 23a 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) 16b. Kind of Business/Industry International of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ò Payroll Clerk Harvester 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward G. Sautter Eva Blottenberger ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence L Lembach Jr. (Son) 805 Francis Avenue, Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State *4 □Donation 5 □ Other (Specify) Cedar Hill Cemetery 05-06-05 Brooklyn Park,Maryland Name and Address of Facility
Cully-Polyniak Funeral Home P.A.
30 E.Fort Avenue, Baltimore, Maryland 21230 21. Signature of Euneral Service Licenses 22. Na McC1 130 a. Jant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician anteur Myscardial 300 mm /Medical Due to (or as a consequence of): **Examiner** Henry Sclenke Curche various Diseus Hypertersun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-translt Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No cate 2 No 1 Yes 1 Yes certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1. Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) west Du 17396e 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Durt 105 E 31. Date filed (Month, Day, Year) MAY 05 32. Redistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2005

Developers the twen first windows and management of the control of			•	For State Registrar	State of	Marylan		artmen tificate				lental Hyg	giene	005	15011
## Common Section 1997 Figure 19 Figu		DI		1. Decedent's Name (First, Middle, Last)										Year	3. Time of Death
### ### ### ### ### ### ### ### ### ##			al									May 1,	2005		1:15 P. M
Social Security Numbers 0.5 security Numb		Examin	er			ber)		*		Location	of Death			•	
The Color of the	_					7. Age (In vrs. I	last birthday)		,	If Under	24 Hrs.	8 Date of Birt			
The Color of the				1.0				Months	Days	Hours	Min.	May 13.	1920		
Roy L. Libby Wilma J. Conley Wilma J. Conle						100 01	Town or Lie								
Roy L. Libby Wilma J. Conley Wilma J. Conle		shoy	٦												
Roy L. Libby Wilma J. Conley Wilma J. Conle		28a-f	ect		.y	Su	ever si	1	Code				10a. Citizen	of What Cou	
Roy L. Libby Wilma J. Conley Wilma J. Conle		3a or	٥	2600 Edfinn Road				200	904-	4525			-		
Roy L. Libby Wilma J. Conley Wilma J. Conle		death	nera		2. Was Dece	dent Ever in U.	S. 13.	Was Deced	lent of Hi	ispanic Ori	igin? (Sp		14. F	Race - Ameri	can Indian,
Roy L. Libby Wilma J. Conley Wilma J. Conle	9	or the			1 XYes	2 🗌 No	1					, , ,		cifv:	
Roy L. Libby Wilma J. Conley Wilma J. Conle	Ś	hours tural	q pa			tes:	16a Dece	tent's lieus	i Occupa	ation		1	16b Kind of		
Roy L. Libby Wilma J. Conley Wilma J. Conle		n na	piet	(Specify only highest grade	completed)	40r 5+\	(Give	kind of wor DO NOT us	k done d e retired	during mos	st of work	ing	rob. Kind of	Dusinesarii	loustry
Roy L. Libby Wilma J. Conley Wilma J. Conle	7	giene giene er tha	Com		College (1	401 54)	Auto	omotiv	se T	echni	ciar	ı	Reta	il	
Register Properties Prope	2	be tile ta! Hy d oth	Be											ame)	
Mns. Helen Libby - Wife 200 Edition Road, Silver Spring, MD. 20904-4525 20a Mathod of Disposition 10 Brand 2 (Command 2	<u> </u>		²				401 11 11		10:						
Bautio 2 Month Survival 2 Month Survival	Mar	d 2 sh th and 7 is n traum													
Bautio 2 Month Survival 2 Month Survival	ກຸ	tem 2				20b. P						Date	20c. Locatio	n - City or T	
21. Sprawler of Funeral Service Libraries MO889 22. Name and Address of Facility Fieck Funeral Home, Inc. 7601 Sanuty Spring Road, Laurel, MD. 20101 Approximate Interval Believe Interval Bel	2	Pages ient o nt: tf			moval from S					" (05-0	4-05	Laurel	. MD.	
Physician Medical Examinary 21 Part Eties to disease, or complications tarksussed the death. On orienter the mode of dying, such as cardiac or respiratory arrest, increased interval Between Approximate Interval Between	<u>a</u>	rmit. spartm porta y inju		21. Signature of Funeral Service License	e ^	,	22	. Name an	d Addres	s of Facili	ty Fi	eck Fun	eral H	ome,	Inc.
Physician Modical Examinor Physician Modical Examinor Physician Physici		89 = 88		A. Diff	2									MD. 2	0707
Physician Medical Examinor Physician Medical Examinor Physician Physici				snock, or hear failure. List only on	ation that e cause of a	used the death ich line.	n. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory ar	rest,		Interval Between
Securation Secur				disease or condition	[4	Spir	anu	14	PY	WILL	m	MIC		· ·	velke)
Due to (or as a consequence of): Comparison of the control of t					Due to (d	orast consequ	uence of):	Culo	-	m v e	c. C.	24			month
The search of th	Ļ		Jer	Sequentially list conditions, if any, leading to immediate	Due to (d	or as a consequ	uence of):	CQTO		0000	(· · · · · ·
Second S	J	cuted nd ransit	amir	that initiated events C.											[4
FFEMALE: 23c. If yes, outcome of pregnancy 1 1 1 2 Fefal death 3 Ectopic pregnancy 1 1 1 1 1 1 1 1 1	Š,	oe exe cian a urial-l		resulting in death) Last	Due to (d	or as a consequ	uence of):								
Sa. Was case referred to medical search of the completion of cause of death? Company of the completion of cause of death of the completion of cause of death of the completion of cause of death? Company of the completion of cause of death. Company of the completion of cause of death? Company of the completion of cause of death? Company of the completion of cause of death. Company of the company of t	0	physic		d.											
The state of the s	_	certifi nding use as	√Me										23d. I	Date of deliv	ery
The state of the s	0	death e atte	icia	in the past 12 months?	4 ☐ Pregna	int at time of de									•
The state of the s	<i>y</i> .	at the by the	hys	9 🗆 Unknown				_							
Second S	, S	res the	by	Part II. Other significant conditions conf	tributing to de	ath but not resu	ulting in the u	nderlying ca	ause give	en in Part I					
Second S	5	requi	eted	ACTURE VOIL	1	cy) we	vija	// ()							
25. Was case referred to medical examiner? 1 Vest 2 No No No No No No No		e iay has je 2	mpl	362M	719							autop	sy	prior to co	opsy findings available impletion of cause of
State Control of the control of	<u> </u>	ificate	O	25. Was case referred to medical						26 Place	a of Doat			1 🗆 Yes	2 No
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Check only one) 29a. Certifier Check only one) 29b. Signature and dittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Registrar's Signature 34. Date filed (Month, Day, Year) 35. Registrar's Signature 34. Date filed (Month, Day, Year) 35. Registrar's Signature 35. Date filed (Month, Day, Year) 35. Registrar's Signature 35. Date filed (Month, Day, Year) 36. Date filed (Month, Day, Year) 36. Date filed (Month, Day, Year) 36. Date		ysicia is cert directi	0	examiner?	ospital:	patient 2	ER/Outpatier	it 3 □ DO	A Othe					Other (Specia	(v)
State		ng Ph ter th neral			28a. Date o	f Injury n, Day Year)		2	Bc. Injury Work	at					
29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	SIO		catic	2 Accident investigation				М	1 🗆 '						
29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	5	or Ati	ertifi	dotominod				eet, factory	, office					m <i>ber or Rur</i> a	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROMER AM MUSHIXE HILHARU UCRSIVE HOME STUREPED A 31. Date filed (Month, Day, Year) 32. Registrar's Signature	_	spitatiours cours and peral		29a. Certifier 1 Certifying Phys	icien: To the	best of my kno	wledge, deatl	n occurred	at the tim	ne, date an	nd place.	and due to the o	ause(s) and	manner as s	itated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROMER AM MUSHIXE HILHARU UCRSIVE HOME STUREPED A 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ne Ho ne Ful sletely	edica	(Check only 2 Medical Examin	er: On the ba	sis of examinat	tion and/or in	vestigation,	in my or	oinion, dea	th occur	red at the time, o	date and plac	e, and due t	o the cause(s)
RAMILA M. MUSHIXIE HILLHAVEN NURSING HOME STURESON		To the To the Comp	ž	29b. Signature and little of certifier	111			290	. License	number	0		29d. Date sig	ned (Month,	Day, Year)
RAMILA M. MUSHIXIE HILLHAVEN NURSING HOME STURESON		18		· Kuu	M	_		0	2	>0 C) 1		May	13	2005
31. Date filed (Month, Day, Year) 32. Registrar's Signature		3		30. Name and address of person who con	mpleted cause	of death (Item	23a) (Type,	Print)	611	10	-10	TIAN.	Marie	5 ()-	11 recomme
Registrar MAY 0 5 2005 Registrar M Avail 6		Sta	te		32. Re	gistrar's Signa	ture	THU	CIU	M	110	JUN)	TUTTE		WELDKUL
				MAY 0 5 21	005	Police -	K	house.	B						

DHMH 17 Rev 1/2001

Bleen & foods

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Nancy Louise Lyons 03 May 2005 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 344 Hunner Road Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 122-38-2066 1 ☐ M 2 🂢 F Yrs. 59 **Director** 16 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at Maryland Anne Arundel Pasadena 1 ☐ Yes 2 ☒ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 344 Hunner Road 21122 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 1 and 2 should be filed within Health and Mental Hygiene. em 27 ia marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Authur ٥ Lyons Mariorie Small traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: if item 27 is Dorothy Wade 344 Hunner Road, Pasadena, MD 21122 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 04 20c. Location - City or Town, State May 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: ff any injury or once. injury or ⁴ 4 ☐ Donation 5 Other (Specify) Metro Crematory Inc. 2005 Baltimore, Maryland 21. Signature of Fineral Service Lic 100 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Carcinoma Of The Ovary year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year Month Dav 4∏Pregnant at time of death 5 Other (specify) the P.O. 9 Unknown 9 Unknown څ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after death Funeral Director: 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D 1 ★ Contying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and tij e of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 Voilh D0014253 May 03, 2005 30. Name and dress of n who completed cause of death (Item 23a) (Type, Print) M.D., Majorie A./Voith, 2702 Parkview Drive, Riva, MD 21140-1017 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 0 5 2005

Baltimore, Maryland 21215-0036

Please Type or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible
			and the same of the same

State of Maryland / Department of Health and Mental Hygiene [] [] [5] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Barbara Letwinsky 2005/2:05 AM Jean mai 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel North Arundel Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2XX 331-30-0395 67 Yrs Illinois Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked othar than "natural", or itama 23a or 28a-f show traumatic evant, the Medical Examinar must be notillied at Director Anne Arundel Odenton 1 ☐ Yes 2XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 Summer Hill Drive 21113 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hyslene.
Important: If item 27 is marked other than "na any Injury or other traumatic event, If a Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James McGill Helen White 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1018 Summer Hill Drive, Odenton, MD 21113 Carl Letwinsky (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Our Lady of the Fields 5/4/2005 Millersville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 n d 23a. Part 1. Enter the disease, or com shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thy one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancer disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Dreumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a conse physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 si 2 No 1 Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient P 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28c. Injury at Work? Date of njury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ay enom) May 01, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Arundel Hospital, Glen Burnie th mo Laiyemo AdeyinKa

State

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician:

after death.

Registrar

amend item#2, permit C843, 5/27/03 Amend Item#1, per PHY, G843, 5/10/05, Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAGGIE K. MOORE Month May ×20054:20 Am Day **Physician** GUG 16 /Medical 4a Facility Name of not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor sa ltimore Care If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 201 Months Days 9 Yrs. 217-24-8265 Usual Residence of Decedent Director MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 HYes 2 No Funeral Director 1timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S.
Armed Forces?
1 | Yes | 2 | No
If Yes, Give
Year or Dates: 45/ 1100 Pennsylvania 2120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 Specify. þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th omestic Jomesti C 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Uniel Johnson NGrner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) God Dayste 9011 Hamor ilhelmenia Stayn Kanda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cenMant Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 6 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mation Sel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner g physician and as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? +RF 1 | Yes 2 | No 3 | Probably 4 | Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? page 2 should 1 Yes 2410 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 2 Medical 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name and addies ed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Greene Tree Vel

State

Registra

31. Date filed (Month, Day, Year)

MAY 0 5

2005

		Registrar			Cei	rtificate of	Deam		Reg. No	0.000	
- voicion	1.	Decedent's Name (First, Middle, L	ast)				-	2. Date of Month	Death Da	Year	3. Time of Death
hysician Medical		PHILLIP KEVIN N	MURCH					APRII		3 2005	10:35P
xaminer	4a	Facility Name (If not institution, graph of the FREDERICK MEMORE)				4b. City, Town,		Death		c. County of Death	
	5				last birthday)	FREDERI		4 Hrs. 8. Date of	Dieth	REDERICK	
neral ector		265-11-3972	1⊠M 2□F	43	Yrs.	Months Days		Min. (Month,	Day, Year	1961 Flo	place (State or Fore intry) rida
	U	sual Residence of Decedent						000.	,	1701 110.	LIGG
T TEL	1	Da. State 10b. County		10c. City	y, Town or La	cation					10d. Inside City Lin
be natified		Florida Broward		Mira	mar	Т-					1 ∑ Yes 2□
Dire	10	De. Street and Number				10f. Zip Code			10g. Ci	itizen of What Cou	intry?
eral	1	17004 S.W. 39th 1. Marital Status	12. Was Decede	nt Ever in II	S 13 1	Was Decedent of	33027	in? (Specify Yes or		ted State	
of sectors of tems 238 of 2881 show dies Executed at the restlict at the decided by Funeral Director		1 Never Married 2K Married	Armed Force	s?	3.	If Yes, specify Cu	ban, Mexican,	Puerto Rican, etc.	1100	Black, White	
by By	•	3 Widowed 4 Divorced	If Yes, Give Year or Date	_		1 ☐ Yes 2 🗓 No	Specify:			Specify:	White
t, the Medical E		15. Decedent's (Specify only highest g	Education		16a. Dece	dent's Usual Occi	upation	of working	16b. k	Kind of Business/Ir	ndustry
nple		Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT use retir	ed)	or working			
S P			1		Sales	sman	T			tdoor Li	ghting
even Be		7. Father's Name (First, Middle, Las	51)				18. Mother	's Name (First, Mic	ldle, Maidei	n Sumame)	
aumatic event, the Manager To Be Comp		Paul Murch	(Tuna Brief)		10h 14=1"	ng Add (C)		a Kane	mbo = 0'*	or Town, State, Zi	= Codo¹
item 27 is marked other their neture other traumatic event, the Modical To Be Completed		9a. Informant's Name/Relationship Aileen Murch/Wif								or Town, State, Zij	,
other tra	_	Oa. Method of Disposition	<u>e</u>	20b. P		sition (Name of	JEII COU	Date		ocation - City or T	
0 0 0		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		™ Our	Lady	Queen o	- 1	E 200			
Important: If any njury or once.	2	21. Signature of Funeral Service_Lic				emetery 2. Name and Add				th Lauder	
any r	ļ	Marget -	1200 AZ	100	— Ki	raeer Fu	neral H	lome & Cr	emati	old Cerre	r 1 33071
	2	23a. Part1. Enter the disease or co shock, or heart allure List on	mplications that caus	sed the death	n. Do not ent	ter the mode of dy	ing, such as c	ardiac or respirato	y arrest,	C ST	Approximate
sician	1	mmediate Cause (Final				M HO				7 /2	Onset and Death
dical	r	disease or condition esulting in death)	_ a	as a consequ		,, ,,,	_ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	770.4		13/1/2	1-1/1401
niner					uerice or,					- T P	
		Conventially list conditions	h (L E	DEM	A		Se Se	HOUR
ner	if	Sequentially list conditions, any, leading to immediate cause. Enter Underlying	Due to (or	ERE as a consequ	B/2 A) uence of):					" Ked	HOUR
transit	if	Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) I ast	Due to (or	CERE as a consequ	B/2 A uence of):			LOPAT	HY	world and and	,
ctan and burial-transit ai Examiner	t	Jause (Disease or injury	c. Due to (or	CERE as a consequence VOXI as a consequence	B/2 A uence of): C uence of):	ENCE	PHA	LOPAT		Drowed Ray K	HOURS
the bur	t	hat initiated events	c. Due to (or	CERE as a consequence VOXI as a consequence	B/2 A uence of): C uence of):	ENCE	PHA			Approved Dank	,
physicis ts the burners edicai	tl	Ause (Disease or injury hat initiated events esulting in death) Last	c. Due to (or Due to (or d.	as a consequence of the conseque	uence of): Cuence of): CARI	ENCE	PHA	LOPAT		40	HOURS
attending physicis for use as the bus ian/Medical	tl	Ause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. Due to (or	as a consequence of the consequence of pregnance of pregnance of the consequence of the	uence of): C C C C C C C C C C C C C	ENCE	PHA Zn	LOPAT		23d. Date of delive Month	HOURS
attending physicis for use as the bus ian/Medical	tl	Ause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant	Due to (or Due to (or d	as a consequence of pregnant 2 Fetal tat time of di	uence of): C C C C C C C C C C C C C	ENCE DI AL	PHA Zn	LOPAT		23d. Date of deliv	HOURS HOURS
attending physicis for use as the bus ian/Medical	the result of th	Ause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or Due to (or d. 23c. If yes, outcor 1 Live birth 4 Pregnan 9 Unknown	as a consequence of pregnance of pregnance at at time of directions.	uence of): Cuence of): CARI Incy I death 35 eath 55	ENCE DE AL Ectopic pregnan Other (specify)	EPHA Zn	LOPAT FRAC	T10/1	23d. Date of deliv Month	HOURS HOURS Pery Day Year
igned by the attending physicis be detached for use as the but by Physician/Medical	ti r	F FEMALE: 13b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or Due to (or d. 23c. If yes, outcor 1 Live birth 4 Pregnan 9 Unknown	as a consequence of pregnance of pregnance at at time of directions.	uence of): Cuence of): CARI Incy I death 35 eath 55	ENCE DE AL Ectopic pregnan Other (specify)	EPHA Zn	LOPA 7	T/O/N	23d. Date of delive Month	HOURS rery Day Year
igned by the attending physicis be detached for use as the but by Physician/Medical	ti r	Ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown art II. Other significant conditions	Due to (or C. Due to (or d. 1 23c. If yes, outcor 1 Live birt 4 Pregnan 9 Unknown	as a consequence of pregnant 2 Fetal tat time of definition of the but not result as a consequence of the but not result as a consequen	uence of): Cuence of): CARI Incy I death 3[eath 5[ENCE DE AL Ectopic pregnan Other (specify)	EPHA Zn	23e. [Oid tobacco	23d. Date of delive Month use contribute to (2 XNo 3 Pro	HOURS HOURS THOURS
has been signed by the attending physicis parts to so as the burn of a storid be detached for use as the burn prefet by Physician/Medical	ti r	F FEMALE: 13b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or C. Due to (or d. 1 23c. If yes, outcor 1 Live birt 4 Pregnan 9 Unknown	as a consequence of pregnant 2 Fetal tat time of definition of the but not result as a consequence of the but not result as a consequen	uence of): Cuence of): CARI Incy I death 3[eath 5[ENCE DE AL Ectopic pregnan Other (specify)	EPHA Zn	23e. [24a. v	Old tobacco Yes 2 Vas an utopsy	23d. Date of delive Month use contribute to 12 No 3 Prof	HOURS HOURS Pery Day Year the cause of death bably 4 Unknown Opsy findings avail completion of cause
rate has been signed by the attending physicis page 2 should be detached for use as the but Compieted by Physician/Medical		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	Due to (or c	as a consequence of pregnant 2 Fetal tat time of definition of the but not results.	uence of): Cuence of): CARI Incy I death 3[eath 5[utting in the u	ENCE DE PL DEctopic pregnand Other (specify) Inderlying cause of	Cy Cy 26. Place C	23e. [1 24a. v a p 1 2 Y of Death (Check or	Oid tobacco Yes 2 Vas an utopsy erformed?	23d. Date of delive Month use contribute to 1 2 No 3 Prof 24b. Were autorior to control death? 1 Yes	HOURS HOURS HOURS Year The cause of death bably 4 Unknown Opsy findings availa ompletion of cause 2 No
rate has been signed by the attending physicis page 2 should be detached for use as the but Compieted by Physician/Medical	ett n 2 P 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or C. Due to (or d. 1 23c. If yes, outcor 1 Live birt 4 Pregnan 9 Unknown	as a consequence of pregnant 2 Fetal tat time of definition of the but not results.	uence of): Cuence of): CARI Incy I death 3[eath 5[utting in the u	ENCE DE AL DEctopic pregnan Other (specify) Inderlying cause of	cy 26. Place of them: 4 \(\text{Nurse} \)	23e. [1 24a. v a p 1 2 Y of Death (Check or	Oid tobacco Yes 2 Vas an utopsy erformed?	23d. Date of delive Month use contribute to 12 No 3 Prof	HOURS HOURS HOURS Year The cause of death bably 4 Unknown Opsy findings availa ompletion of cause 2 No
ther this certificate has been signed by the attending physicis neral director, page 2 should be detached for use as the but a first transfer of the completed by Physician/Medical on: To Be Completed by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or c. Due to (or d. Due to (or d. All Live birth 4 Pregnan 9 Unknown contributing to death Hospital: 1 Pring 28a. Date of I	as a consequence of pregnance of pregnance of pregnance of the pregnance o	uence of): Cuence of): CARI Incy I death 3[eath 5[utting in the u	ENCE DE AL DEctopic pregnan Other (specify) Inderlying cause of the second of the s	cy 26. Place of ther: 4 \(\text{Nur:} \) ury at ork?	23e. [24a. v 25 of Death (Check or sing Home 5 F	Olid tobacco Yes 2 Was an utopsy enformed? Se 2 No.	23d. Date of delive Month use contribute to 1 2 No 3 Prof 24b. Were autorior to control death? 1 Yes	HOURS HOURS HOURS Year the cause of death' bably 4 Unknown Opsy findings availa ompletion of cause 2 No
ther this certificate has been signed by the attending physicis neral director, page 2 should be detached for use as the but a first transfer of the completed by Physician/Medical on: To Be Completed by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2art II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 25. Wanner of Death 1 Natural 5 Pending investigat 2 Vaccident investigat 3 Suicide 6 Could not	Due to (or c	me of pregnal tat time of definition to the but not result attent 2 miles attent	uence of): Cuence of): CARI Incy I death 3[eath 5[uiting in the ui	ENCE DEFL DEctopic pregnand Other (specify) Inderlying cause of the second of the s	cy 26. Place of ther: 4 Nursury at ork?	23e. [1 24a. v a p 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	olid tobacco Yes 2 Vas an utopsy erformed? s 2 No. No. No. No. No. No. No. No.	23d. Date of delive Month use contribute to 1 2 No 3 Prof 24b. Were autorior to control of the	HOURS HOURS HOURS Year The cause of death/i bably 4 Unknown Opsy findings availa Oppy findings availa Oppy findings availa Oppy findings availa
ther this certificate has been signed by the attending physicis neral director, page 2 should be detached for use as the but a first transfer of the completed by Physician/Medical on: To Be Completed by Physician/Medical	P 2	Ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 17. Manner of Death Natural 5 Pending investigat investigat	Due to (or c. Due to (or d. Due to (or location beaution of the contribution of the contribut	me of pregnal tat time of definition to the but not result attent 2 miles attent	Lence of): C puence of): ER/Outpatier 28b. Time of Injury Dome, farm, str	ENCE DE AL DEctopic pregnan Other (specify) Inderlying cause of the second of the s	cy 26. Place of ther: 4 Nursury at ork?	23e. [24a. v 24a. v 1 Yo of Death (Check or 28d. Describe	olid tobacco Yes 2 Vas an utopsy erformed? s 2 No. No. No. No. No. No. No. No.	23d. Date of delive Month use contribute to the	HEURS rery Day Year the cause of death? bably 4 Unknot opsy findings availa mpletion of cause 2 No
ther this certificate has been signed by the attending physicis neral director, page 2 should be detached for use as the but a first transfer of the but a first transfer	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	Due to (or c. ———————————————————————————————————	as a consequence of the conseque	uence of): Cuence of): CARI Incy I death 55 Leath 55 ER/Outpatier 28b. Time of Injury Dome, farm, stry)	ENCE DEPL DEctopic pregnan Other (specify) Inderlying cause of the second of the se	cy 26. Place of them: 4 Nursury at ork? 29. Place of them: 4 Nursury at ork?	23e. E 24a. v 25 p 1 p 24a. v 25 p 1 p 26 p 28d. Describe	on (Street a Town, Stat	23d. Date of delive Month use contribute to 1 2 \(\begin{align*} \text{No} & 3 \cup \text{Prof to coord} \) 24b. Were autor prior to coord of the	HOURS HOURS HOURS Year The cause of death? bably 4 □Unknot Dopsy findings availation of cause 2□ No fy)
ther this certificate has been signed by the attending physicis neral director, page 2 should be detached for use as the but a first transfer of the but a first transfer	P 2	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 26. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural S Pending 2 O C A T 28. Was case referred to medical examiner? 2 No O C A T 29. Certifier 1 Certifying	Due to (or c. Due to (or d. Due to (or line be an accordance of lower of lower of lower of lower of lower of building. Physician: To the beaminer: On the basi	as a consequence of pregnant 2 Fetal tat time of did to the but not result at time of	uence of): Luence of): CARI death 3[eath 5[ER/Outpatier 28b. Time o Injury owne, farm, str	ENCE DEPL Ectopic pregnand Other (specify) Inderlying cause of the second of the se	cy 26. Place of ther: 4 Nursury at ork? Yes 2 Nursury at ork?	23e. L 24a. V ap 1	Olid tobacco Yes 2 Was an utopsy enformed? ss 2K No. No. young. Town, Staff the cause(steeped and town, Staff the cause(steeped and town).	23d. Date of delive Month use contribute to the contribute of the contribute to the contribute of the	HOURS HOURS HOURS Ferry Day Year the cause of death bably 4 Unknown Dopsy findings availa Dopsy findings ava
ther this certificate has been signed by the attending physicis neral director, page 2 should be detached for use as the but a first transfer of the but a first transfer	2 P 2 2 2	Ause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2art II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Vaccident 5 Could not determine 29a. Certifier Check only 2 Medical Ex	Due to (or c	as a consequence of pregnance o	uence of): Luence of): CARI death 3[eath 5[ER/Outpatier 28b. Time o Injury owne, farm, str	ENCE DE PL DEctopic pregnan Other (specify) Inderlying cause of the second of the s	cy 26. Place of ther: 4 Nursury at ork? Yes 2 Nursury at ork?	23e. L 24a. V ap 1	olid tobacco Yes 2 Vas an utopsy enformed? so 250 No.	23d. Date of delive Month use contribute to the contribute of the contribute to the contribute of the	HOURS HOURS HOURS Ferry Day Year the cause of death' bably 4 Unknown Dopsy findings availa Dompletion of cause 2 No fy) al Route Number, stated, o the cause(s)
he Funeral Director: After this certificate has been signed by the attending physicis pletaly filled in by the funeral director, page 2 should be detached for use as the but a funeral director. To Be Completed by Physician/Medical edical Certification: To Be Completed by Physician/Medical	2 P 2 2 2	Ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or c. Due to (or d. Due to (or lead of the birth All Pregnan Guntributing to deat Bullding Physician: To the bear and manner Physician: To the basis and manner	as a consequence of pregnance o	uence of): Luence of): CARI death 3[eath 5[ER/Outpatier 28b. Time o Injury owne, farm, str	ENCE DE PL DEctopic pregnan Other (specify) Inderlying cause of the second of the s	cy 26. Place of their 4 Nursury at ork? Yes 2 Nursury at orpinion, death orpinion, death onse number	23e. I 24a. V 24a. V 1 Y of Death (Check or sing Home 5 F 28d. Describe 28d. Locatic City or	olid tobacco Yes 2 Was an utopsy erformed? ss 2K No. No. (Street a Town, Stat) the cause(sme, date an 29d. Do.	23d. Date of delive Month use contribute to the contribute of the contribute to the contribute of the	HOURS HOURS HOURS Pery Day Year the cause of death/ bably 4 Unknown Dopsy findings availa
ther this certificate has been signed by the attending physicis neral director, page 2 should be detached for use as the but a first transfer of the but a first transfer	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or c	as a consequence of the conseque	uence of): Cuence of): CARI uncy I death 3E eath 5E ER/Outpatier 28b. Time o Injury ome, farm, str	ENCE DEPL Ectopic pregnan Other (specify) Inderlying cause of the second of the sec	cy 26. Place of ther: 4 Nursury at ork? Yes 2 Nursury at ordine, date and opinion, death and opinion, death	23e. E 24a. V 24a. V 25 of Death (Check or Sing Home 5 Properties) 28d. Describe 28f. Locatic City or place, and due to noccurred at the time of the control	oid tobacco Yes 2 Vas an utopsy erformed? so 2 No.	23d. Date of delive Month use contribute to the contribute and prior to contribute and the contribute and Number or Runder (Special and Number or Runder).	HOURS HOURS HOURS Pery Day Year the cause of death bably 4 Dunknot Days findings available on cause 2 No fy) al Route Number, stated. to the cause(s) Day, Year) O 5

	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. [] [] []										15050
		Decedent's Name (First, Middle, Last)						2. Date of De	* 108	Year	3. Time of Death
Physic /Med		Joyce	Α.		Montal	bano		May	4	2005	2:20A M
Exami	ner	4a. Facility Name (If not institution, give				own, or Locat				ounty of Death .nne Aru	n do 1
Funera		928 Longview A 5. Social Security Number 6. S	ex 7. Age	(In yrs. last birth	day) If Under 1			8. Date of Bi			
Director		214-50-1432	□ M 2□XF	56 Y	rs. Months	Days Hou	urs Min.	8. Date of Bi July 2	20 ^v 194	8 Mar	place (State or Foreign Try) and
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	Od. Inside City Limits
Maryla f sho	ō	Maryland Anne Aru	ındel		adena						1 ☐ Yes 2 ☐ No
n the	Director	10e. Street and Number			10f. Zip (Code			10g. Citize	n of What Cour	ntry?
th with	ai D	928 Long	view Ave.			21122			U	SA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or itsms 23a or 28e-f show any injury or other traumatic event, it a Modical Expediture is not be nutilised at any once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		13. Was Deceded If Yes, specifical Yes 2.			rify Yes or No lican, etc.)		. Race - Americ Black, White, pecify: Wh	
5-0 72 hc	etec	15. Decedent's Ed (Specify only highest gra		16a. i	Decedent's Usual Give kind of work	Occupation done during	most of workin	t of working		6b. Kind of Business/Industry	
within within the series.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	(Give kind of work done during most of working life. DO NOT use retired) Supervisor Fitness				tness		
IG 2	Be Co	17. Father's Name (First, Middle, Last)			ouper (lother's Name	(First, Middle			
/lan	To B	Everett			Barton		D	Eileen)	Pramsc	hafer
Taryla 2 should I and Men is marke		19a. Informant's Name/Relationship (Louis Montalbano	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural) 928 Longview Ave. Pasade						Code)
e, N 1 and Health Bm 27 thar t		20a. Method of Disposition	spouse		Disposition (Name		• Pasau			tion - City or To	own State
Pages nent of in		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		cemetery	r, crematory or oth Cremator:	er place)	5/7/2	005		imore M	
altimore, mit. Pages 1 ar partment of Hea portant: If item: y injury or otha		21. Signature of Funeral Service Liger		110010	22 Name and	Address of F	acility				
0 2 2 3 3		Myd. 8								eral Ho 21122	me P.A.
		23a. Pan I. Enter the disease, or com shock, or heart failure. List only	olications that caused to one cause on each line	the death. Do no	ot enter the mode	ol dying, such	h as cardiac or	respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Ceadic Cancer 6 Mou									
Examiner			Due to (or as a	consequence of	1):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
18760, Ccate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c									
8760, ate be ex hysician a	aj E	rosulting in assum, East	Due to (or as a	consequence of	r):						
687	edicai	`	d								
I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal death	3 □Ectopic pred				230	d. Date of delive Month	ery Day Year
IS, P.O. I	by Ph	Part II. Other significant conditions c	ontributing to death but	t not resulting in	the underlying car	use given in P	art I.	23e. Did 1	tobacco use	contribute to th	ne cause of death?
Records, he law requires t e has been signe age 2 should be o	ed b							1 🗆	Yes 2 🖽	No 3□Prob	ably 4 Unknown
eco lawre as bee	Completed							24a. Was	DSV	24b. Were auto	psy findings available inpletion of cause of
The The page	Com							perfo 1 ☐ Yes	ormed? 2 400	death? 1 ☐ Yes	
Vital Rec sician: The law s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Othor	lace of Death				
Of Phys rr this eral dil	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day		me of 28	c. Injury at	Nursing Hom-	e 5 Resi 3d. Describe		Other (Specify	y)
ISION Attending death. ctor: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) In	ury M	Work? 1 ☐ Yes 2	2 □No				
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)					28	281. Location (Street and Number or Rural Route Number, City or Town, State)			
Hospi 24 hou Funai etely fil	Medical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as tated.								ated. the cause(s)	
Fo the within Fo the	B e	29b. Signature and title ol certifier	~ ·)	29c. License number				29d. Date signed (Month, Day, Year)			
		Conort		D39505 Hospital Dv. Glan B			may 4,2005				
3		30. Name and address of person who	completed cause of de-		ype, Print) HoSpi	tal D	v. Gl	on B	ium	ie, r	1D 21061
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar	-							
DHMH 17 Rev 1/		MAY 0 5 200	5	, St	(See E)						
				ORIG	INAL						

		-	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 5 2								
	Physicia	an	. Decedent's Name (First, Middle, Last) ROMAINE ANNETTE		MATTHEW	S		2. Date of Death Month Day Yea		3. Time of Death 4:30a	
}	/Medic Examin		4a. Facility Name (If not institution, give street and number) 1642 Lochwood Court			4b. City, Town, or Location of Death Baltimore			4c. County	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir (Month, Date of Port)	th ly, Year)	9. Birthp Cour	-
T	ס		Usual Residence of Decedent 10a. State 10b. County		ly, Town or Lo		l	J-12-	23	1	Md .
	the Mar 28a-f sl	Director	Md. NA Balt 10e. Street and Number			imore			10g. Citizen of W	/hat Cour	1 X Yes 2 □ No
	s 23a or	rai Di	1642 Lochwood Court			2121				USA	
	urs after de al', or Itam	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3X Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	Vas Decedent of Hi fYes, specify Cuba □ Yes 2√□ No	ispanic Origin n, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)		k, White,	can Indian, etc. lack
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itams 23a or 28a-1 show amportant: If Item 27 is marked other than "natural; or Itams 23a or 28a-1 show appring to other traumatic event, It is Marical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	during most of	f working	16b. Kind of Bus		dustry
	e filed w Il Hygier other th	Be Cor	12+ yrs 17. Father's Name (First, Middle, Last)		Cosi	metologis		Name (First, Middle	Varies		
Maryland	hould be d Menta marked matic ev	ToB	James 19a. Informant's Name/Relationship (Ty,	Lewis	19h Mailin	a Address (Street		or Rural Route Numb		vis	Codo
Baltimore, Mai	and 2 s ealth an n 27 is i		Jacqueline Tubman	Daughte	r 16	42 Lochwo		rt, Balti	nore, Md.	. 2]	1218
	Pages 1 ent of H nt: If Iten 'y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, cren	sition (Name of natory or other plac unt Cem.	1_	Date -4-05	20c. Location - 0		
Balti	permit. I Departm Importal any inju		21. Signature of Funeral Service License	. //		. Name and Addres March E	ss of Facility	Balt	imore, M	d.	21202
8760, <	Ilicate be executed Medical Examiner the burial-transit	dical Examiner	23a. Part1. Enter the disease, or compliance, which, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence).	quence of):	er the mode of dying	g, such as ca lial Ja	or respiratory a Dinfr	nelion	1	Approximate Interval Between Onset and Death
	ne death certi the attending hed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year
s, D	quires that the signed by old be detacted.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 F								
Division of Vital Record	ician: The law requir certificate has been si ector, page 2 should	Completed						24a. Was auto pend 1 Yes	psy pr prmęg? de	rior to cor eath?	psy findings available mpletion of cause of
	di S	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X()No		ER/Outpatien	t 3□ DOA Othe	20	Death (Check only only only only only only only only		r (Specif	у)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Ceath Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	M 1 ☐ Yes 2 ☐ No			28d. escribe how injury occurred			
	tal or At s after d al Direct ed in by	Medical Certifi	4 Homicide determined							I Route Number,	
	To the Hospital within 24 hours a To the Funeral completely filled		one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owiedge, death ation and/or inv	occurred at the time restigation, in my op	ne, date and pointion, death	place, and due to the occurred at the time,	cause(s) and man date and place, a	iner as st nd due to	ated. the cause(s)
	To To	2	29b. Signature and title of certifier	Tripelle	aein	D 3	0661		29d. Date signed May 4	(Month,	2005
	4		30. Name and address of person who co	mpleted cause of death (Item	7 23a) Type,	Ballin	eu.	Hd -	21239	7	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 20	32. Pegistrar's Signa	B A	and i					

amend item#16a, 19a-b, per Hi, 6843, 575/05 TT

			For State Registrar		partment of Health and Nertificate of Death	Mental Hygie Reg.	0000)			
	Physici /Medic		Decedent's Name (First, Middle, Last) PEARL		MYROWITZ	2. Date of Death MAY 3, 20	Day Year 3. Time of Death				
	Examin		4a. Facility Name (If not institution, give stre MILFORD MANOR NURS)		4b. City, Town, or Location of Death		4c. County of Death BALTIMORE				
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda) 2 7 F 90 Yrs.		8. Date of Birth Month Day, Ye	Q Right place (Ctate or Forei	ign			
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location	1000	1914 LITHUANIA	tc.			
	Maryle 9-1 sho	to	MD BALTIMO		TIMORE.		1 □ Yes 2 N				
5-0036	with the	Funeral Director	10e. Street and Number	MILL DOAD	10f. Zip Code	10g.	Citizen of What Country?				
	death	nera	4204 OLD MILFORD 11. Marital Status 12.		21208 B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - American Indian,				
	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Memlat Hygiene. If Health and Memlat Hygiene. If the Art is marked other than "natural", or items 23e or 28e-1 show other treumetic event, the Mardical Example than the Lydiffed at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🌣 No Specify:	rican, etc.	Black, White, etc. Specify: WHITE				
21215-0036	in 72 h	Completed	15. Decedent's Educati (Specify only highest grade co	lile lile	eedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	king 16b	. Kind of Business/Industry				
	filed within Hygiene. sther than " ent, the Mas		Elementary/Secondary (0-12)	College (1-4or 5+)			RY GOODS				
larylan	2 should be filed withir and Mental Hygiene. Is marked other than eumetic event, Ite M.	To Be	17. Father's Name (First, Middle, Last) ABRAHAM	SMI		ne (First, Middle, Maid ROCH					
	1 and 2 sho Health and I iem 27 Is me sther treume		19 SOTO Name/Relationship (<i>Type</i>	fusband 5833	iling Address (Street and Number or Rui Park Heights 1 SLADE AVENUE - B	ral Route Number, Ci ALTIMORE,	ty or Town Flate Zip Code) MD 21208				
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or othe once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ Rem	oval from State	rematory or other place)		. Location - City or Town, State				
altim	permit. Pa Departmen Importent: eny injury once.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee				OODLAWN, MD	-			
Ä	Depar Impoor		> Edward (Ke		8900 REISTERSTOWN	ROAD - PII					
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Onset and Death								
	The law requires that the death certificate be executed with the death certificate be executed with a signed by the attending physicien and beginning by should be detached for use as the burial-transit		resulting in death) Due to (or as a consequence of):								
		iner	causé. Enter Undertying Cause (Disease or iniqury that initiated events resulting in death) Last Due to (or as a consequence of):								
/ o		Examin									
68760,	icate be physici s the bu	edicai	d								
Вох	leath certifi attending I for use as		IF FEMALE: 23b. Was decedent pregnant 23c.		23d. Date of delivery Month Day Year						
.O.	the dea by the at ached fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death 59 Unknown	i ☐ Other (specify)		Month Day Year				
ds, P.	ires that the de signed by the a d be detached f	by	Part II. Dther significant conditions contrib	cco use contribute to the cause of death?							
Records,	aw requir s been si 2 should	Completed	130	24a. Was an	n 24b. Were autopsy findings available						
al Re	ding Physicien:). After this certifica funeral director, p				performed? death? Yes 2 No 1 Yes 2 No						
of Vital		To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	th <i>Check onli one</i> ome 5□ Residence							
o uc											
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospitel or Attens within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only (Ch								
	ro the Printing of the Front of the Fromplete	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)				
)	->-0		I shulle	Deroy	D2674	8 5	13/2005				
	4	1 10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL UB FROI MID 4419 FALLS RO BALTO MD21211								
	Sta Registr		31. Date filed (Month, Day, Year)- MAY 0 5 2005	32. Registrar's Signature	K.						

Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Example of the Medical Example of 28a-6 show and other than "natural", or items 23a or 28a-6 show and the Medical Example of 28a-6 show and, the Medical Example of 28a-6 show and, the Medical Example of 28a-6 show and the Medica	Funeral Director	1 - State Registrar 1. Decedent's Name (First, Middle, Cheryl McCar: 4a. Facility Name (If not institution, Franklin Square 5. Social Security Number 216-80-9842 Usual Residence of Decedent 10a. State 10b. County MD N/A 10e. Street and Number 11 E. Elm Avent	ron give street and number Hospital S. Sex 1 M 2 StF	44 10c. City, 7	Yrs.	4b. City, Town, o Rosedale If Under 1 Year Months Days		2. Date of Dea Month April	26, 200 4c. Count Balti	ty of Deatl	3. Time of Death 2338 P M
15-0036	/Medic Examin	Funeral Director	4a. Facility Name (If not institution, Franklin Square 5. Social Security Number 216-80-9842 Usual Residence of Decedent 10a. State 10b. County MD N/A	give street and number Hospital 3. Sex 7. A	44 10c. City, 7	Yrs.	Rosedale	e If Under 24 Hrs.	8 Date of Birt	4c. Count Balti	ty of Deatl	
5-0036	Funeral Director	Funeral Director	Franklin Square 5. Social Security Number 216-80-9842 Usual Residence of Decedent 10a. State MD N/A 10e. Street and Number	Hospital 3. Sex 7. A	44 10c. City, 7	Yrs.	Rosedale	e If Under 24 Hrs.	8 Date of Birt	Balti	•	1
15-0036	Director	Funeral	216-80-9842 Usual Residence of Decedent 10a. State 10b. County MD N/A 10e. Street and Number	1□M 2 5 F	44 10c. City, T	Yrs.			8. Date of Birt (Month, Day 8 / 1 2 / 1	b		
15-0036	hours after death with the Maryland tural; or Items 23a or 28a-f show at Exerter must be notified at	Funeral	10a. State 10b. County MD N/A	A		F			0/12/1	ў, _{Year)} 960	Co	nplace (State or Foreign untry) yland
15-0036	hours after death with the Mary tural', or Items 23a or 28a-f sh ill Exsoriner murt be notified	Funeral	10e. Street and Number	A		own or Loc	ation					10d. Inside City Limits
15-0036	hours after death with the tural; or Items 23a or 28 all Exectment must be not	Funeral			В.	altimo	ore					1 √∑X es 2 ☐ No
15-0036	hours after death v tural', or Items 23a	y Funeral	II E. Elm Aven				10f. Zip Code			10g. Citizen of	What Co	untry?
15-0036	hours after d tural', or Iten	y Fun	11. Marital Status	12. Was Deceden	nt Ever in U.S.	13. W	212		pecify Yes or No	U.S.		ncan Indian,
15-003	hours tural',	3 -	1 ☐ Never Married 2 ☐ Marrie	Armed Forces d 1 ☐ Yes 2 🔀	?		Yes, specify Cuba ☐ Yes 21☑ No	dispanic Origin? (Spanic Ann. Mexican, Puerto	Rican, etc.)	BI	ack, White	e, etc.
<u>।</u>		d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates							ify: Wh	
12	12 should be filed within 72 h and Mental Hygiene. 7 Is marked othar than "na iraumatic evant, the Medic	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-40		(Give k life. D	ent's Usual Occup ind of work done O NOT use retired	during most of world	king	16b. Kind of I		industry
g 5	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, L	ast)		OIII	KIIOWII	18. Mother's Nam	ne (First, Middle,			
ylar	ould by Menta Menta Merked	ToE	Louis W. Boyd						lna Fran			
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationshi Mary Edna Boyd			_		and Number or Ru od Ct. Co				üp Code)
ē,	s 1 an f Heal itam 2 other		20a. Method of Disposition			e of Dispos	ition (Name of atory or other place	1	Date	20c. Location		Town, State
Baltimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		er i	to./Wa	sh. Crem	n. 5/4		Laurel	, Mar	yland
3alt	ermit. Separtr nportu ny inju		21. Signature of Fur eral Service L	censee		22.	Name and Addre	ss of Facility Mi	ller-Di	ppel Fu	nera	1 Home Inc.
	20 = 8 0		23a. Part J. Enter the disease, or othock, or heart failure. List o	omplications that caus	ed the death			ir Road B			Land	21206 Approximate
	Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, france, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Ather	is a consequer	roti(ct vascula	r Dise	ase		Onset and Death
68760	icate be ex physician s the buria	licai		d								
O. Box 6	eath certif attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown		2 Fetal de at time of deat	eath 3 ⊡6	Ectopic pregnancy Other (specify)	у			ate of deli	very Day Year
, P.O.	that the d	by Ph	Part II. Other significant condition	s contributing to death	but not resulting	ing in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use cor	ntribute to	the cause of death?
rds	w requires that been signed b should be deta								101	res 2□No	3 🗆 Pro	obably 4 Unknown
Vital Records,	iician: The law re certificate has be rector, page 2 sho	Completed			-	·				rmed?	Were autorior to death?	topsy findings available ompletion of cause of
ita	stan: artifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	2 No	Ties	2□ No
of V	Physician: this certific ral director,	P	XXYes 2 □ No		tient 2 X EP		3□ DOA Oth	ner: 4 - Nursing H	ome 5 ☐ Resid	dence 6 🗆 O	her (Spec	eify)
ion	Attanding I death. ctor: After y the funer	ation	27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigs		Day Year)	8b. Time of Injury	28c. Injur Wor M 1 □	ryat rk? Yes 2 □ No	28d. Describe h	now injury occu	irred	
Division of	To tha Hospital or Attanding Physician: The within 24 hours after death. To tha Funaral Director: After this certificate h. completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could no determine	28e. Place of I building,	njury - At home etc. <i>(Specily)</i>	e, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Num vn, State)	iber or Ru	ral Route Number,
	na Hospi n 24 houn na Funar oletely fill	ledical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis and manner	of examination	edge, death n and/or inv	occurred at the time stigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)
	To the within the	W	29b. Signature and title of certifier	Ironic	a-Pal	QL.	29c. Licens 0.C.M.			29d. Date sign April 2		
			30 Name and address of person w	tho completed cause of	death (Item 2	ii Per	nn Street	t, Baltim	ore, Mar	cyland	21201	L

Lois B. Osmer 05-3050 AKG

)5() 1 - Stat Regi) strar	State c	i marylar		tificate d			-	giene Reg. No.		
1. Deced	ent's Name (First, Middle,	Last)						2. Date of De	ath	005	3. Time of Death ,
Physician Loi	s Bridget O	smer						May 2,	2005	Year	4:56 P M
	y Name (If not institution,	give street and nu	mber)		4b. City, Tow	n, or Locati	on of Death			ounty of Death	
Sina	i Hospital				Balti	more				n/a	
Funeral 5. Social	Security Number (6. Sex	7. Age (In yrs.	**	If Under 1 Ye Months Da		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da	v. Year)	Con	place (State or Foreign
	62-7598	1 M 2 F	60	Yrs.					1 194	4 C	A A
70	idence of Decedent 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
MD Stor	Baltimo			Hunt '	Valley						1 ☐ Yes 2 No
9 8 10e. Stre	et and Number	re		Tunt	10f. Zip Cod	le			10a. Citize	n of What Cou	
TI S FI	rnace Ct.				21	1030			-	SA	
within 72 hours after death with the Maryland and than "natural", or items 23a or 28a-1 show than Medical Evanither and the maryland and maryland Properties and the maryland an			edent Ever in U		Was Decedent	of Hispanic	Origin? (Spe	ecify Yes or No		Race - Ameri	
Pur Fur Pro	ever Married 2X Marrie	Armed Fo	2 No		f Yes, specify C			Rican, etc.)		Black, White	, etc.
Ours a ours a la by	ridowed 4 Divorced	If Yes, Gi Year or D	ve lates:		1 Yes 2 X	No Spec	эпу:		S	ecify:	white
21215-00 ed within 72 hou ygiene. nar than "natura it, "he Medical Completed	15. Decedent's (Specify only highest	s Education grade completed)		(Give	lent's Usual Oc kind of work do	ne during n	nost of worki	ing	16b. Kind	of Business/Ir	ndustry
C Elemen	tary/Secondary (0-12)	College (_ ′		OO NOT use re	tired)			F.,		
N S S S S S S S S S S S S S S S S S S S	12 's Name (First, Middle, La	act)	5+	Eat	ucator	19 14	othor's Name	(First, Middle		cation	
E SES O	ık Osmer	a31/				10. NK		ne Mur		mame)	
Par Property of Francisco	mant's Name/Relationshi	in (Type Print)		19b Mailir	g Address (Str	eet and Nu			· ·	oum State 7	r Codol
Milli Milli	am A. Lawr		band		ırnace						7 0000)
20a. Meth	od of Disposition			Place of Dispo	sition (Name of	f mlnnal	1 0	Date	20c. Local	tion - City or T	own, State
Baltimore, permit. Pages 1 a Department of Her Important: If Itam any Injury or otha any Injury or otha any Injury or otha	Burial 2 XCremation : Donation 5 ☐ Other (Spe		State	-	natory`or other ; ash. Ci		i dev E	10/05	Laure	I MD	
The same and the s	ture of Fuseral service Li		Dc								
De	ichael J. F	agle	_		Name and Ademmon	Funei	ral Ho a Rd	me of I	Duland	ey Vall MD 21	ey, Inc.
23a. Par	Enter the disease, or c ck, or heart failure. List or	complications that only one cause on e	aused the dear	th. Do not ent	er the mode of	dying, such	as cardiac o	or respiratory a	rrest,		Approximate Interval Between
Immedia	e Cause (Final or condition	Mul	inte Toil	1/7-1 4	AH Com	plica	26- 7				Onset and Death
/Medical resulting	in death)	a. Tron	(or as a consec	quence of):	iti COM	THEAT	(191)				
Examiner Sequenti	ally list conditions,	b							_		
if any, lea	iding to immediate nter Underlying	Due to	(or as a consec	quence of):							
that initial tesulting that initial tesulting	isease or injury ed events in death) Last	C. Due to	(or as a consec	THORSE of):							
physician and physician and sthe burial-transit care in a carmination of the carmination		00010	(OI as a collsec	querice or).							
	,	d									
BOX (Bath certification) attending for use a 23p. Mas in the											
€ 9 L & 200. Was		23c. If yes, ou	tcome of pregna	ancy		-			230	Date of deliv	PDV.
The State of the s	decedent pregnant e past 12 months?	1 Live t	tcome of pregnation of contract at time of con	al death 3	Ectopic pregna				23d	. Date of deliv	ery Day Year
Ithe dea ached for ached for ached for ached for ached for a hysicial	decedent pregnant	1 Live t	ointh 2 ☐ Feta nant at time of c	al death 3					23d		•
s, P.O. Box s that the death cert and the attending of detached for use a detached for use a gray. The standard of the standar	decedent pregnant e past 12 months? Yes 2 No	1⊡Live t 4⊡Pregr 9⊡Unkn	oirth 2 Feta nant at time of c own	al death 3 [death 5 [Other (specify)	art I.	23e. Did to		Month	•
ed by Physiclan/Mee	decedent pregnant e past 12 months? Yes 2 No Unknown	1⊡Live t 4⊡Pregr 9⊡Unkn	oirth 2 Feta nant at time of c own	al death 3 [death 5 [Other (specify)	art I.	23e. Did t	obacco use	Month contribute to t	Day Year
aw requires that the dea as requires that the dea is been signed by the att 2 should be detached to pleted by Physician by the state of	decedent pregnant e past 12 months? Yes 2 No Unknown	1⊡Live t 4⊡Pregr 9⊡Unkn	oirth 2 Feta nant at time of c own	al death 3 [death 5 [Other (specify)	art I.	1 🗆 `	obacco use	Month contribute to t to 3 Prot 4b. Were auto	Day Year the cause of death? bably 4 Unknown bysy findings available
law requires to the state of th	decedent pregnant e past 12 months? Yes 2 No Unknown	1⊡Live t 4⊡Pregr 9⊡Unkn	oirth 2 Feta nant at time of c own	al death 3 [death 5 [Other (specify)	art I.	1 🗆 Y	obacco use yes 2 XN an 2 ssy rmed?	Month contribute to t 3 Prot 4b. Were auto prior to co death?	he cause of death? bably 4 Unknown bopsy findings available mpletion of cause of
law requires to the state of th	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition	1⊡Live t 4⊡Pregr 9⊡Unkn	oirth 2 Feta nant at time of c own	al death 3 [death 5 [Other (specify	given in Pa		1 🗆 Y	obacco use Yes 2 N	Month contribute to t io 3 Prot 4b. Were autoprior to co	he cause of death? bably 4 Unknown psy findings available mpletion of cause of
law requires to the state of th	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition	1 □ Live t 4 □ Pregr 9 □ Unkn as contributing to d Hospital:	inth 2 Feta	al death 3 [death 5 [Other (specify,	given in Pa	ace of Death	24a. Was autor perio 1 Yes	obacco use Yes 2 No an 2 osy rmed? 2 No	Month contribute to t to 3 \sum Prot 4b. Were autor prior to co death? 1 \sum Yes	he cause of death? pably 4 Dunknown posy findings available mpletion of cause of
law requires to the state of th	decedent pregnant e past 12 months? Yes 2 No Unknowh her significant condition case referred to medical ner? es 2 No er of Death	1 □ Live 4 □ Pregr 9 □ Unkn is contributing to d	inth 2 Feta	al death 3 ⊆ death 5 ⊆	Other (specify, anderlying cause	given in Pa 26. Pl. Other: 4 Dijury at Nork?	ace of Death	24a. Was autor performent of Passic Resident Describer 1	obacco use yes 2 1 2 an ssy rmed? 2 2 No one dence 6 0 now injury o	Month contribute to t to 3 \sum Prot 4b. Were autorior to codeath? 1 \sum Yes Courred	he cause of death? pably 4 Unknown posy findings available mpletion of cause of
on of Vital Record	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition case referred to medical ner? es 2 No er of Death atural 5 Pending coident Proportion	Hospital: 28a. Date (Mon	inpatient 2 Feta inpatient 2 man at time of comme eath but not resemble. inpatient 2 man at time of comme al death 3 death 5 death 3 dea	Other (specify) Inderlying cause 28c. If	26. Pl. Other: 4 Jury at Work? Yes 2	ace of Death	24a. Was autop performent of the control of the con	obacco use Yes 2 N an 2 Sisy rmed? 2 No one dence 6 one ow injury o	Month contribute to to to 3 protection and prior to condeath? 1 yes	bay Year the cause of death? bably 4 □Unknown posy findings available mpletion of cause of No	
on of Vital Record	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition case referred to medical ner? es 2 No er of Death atural 5 Pending	Hospital: 28a. Date tition 28a. Pace (Mon 4/20 28e. Place 28e. Place	inth 2 Feta nant at time of co own eath but not res inpatient 2 of Injury	al death 3 death 5 death 6 dea	other (specify) anderlying cause and	26. Pl. Other: 4 Jury at Work? Yes 2	ace of Death	24a. Was autop period 1	an 2 No 2 Street and Non, State)	Month contribute to to the state of the sta	he cause of death? pably 4 Unknown posy findings available mpletion of cause of
on of Vital Record	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition case referred to medical ner? es 2 No er of Death atural 5 Pending investiga cordent uicide 6 Could no determin	Hospital: 28a. Date attion by the led 1 □ Live 4 □ Pregrig 9 □ Unkn 28a. Date 4 20 28e. Place build	inpatient 2 Feta inpatient 2 for input inpatient 2 for input of Injury of Injury - At h ing, etc. (Specia	al death 3 death 5 dea	t 3 DOA 28c. If	26. PI Other: 4 □ Thury at Nork?	ace of Death Nursing Hor	24a. Was autor period 1 Yes 1 Check only of the control of the	an syrmed? 2 No one! dence 6 now injury on the street and North, State)	Month contribute to to to 3 Protection 3 Protection to condeath? 1 Pes Courred	he cause of death? pably 4 Unknown posy findings available mpletion of cause of No (((()))(())(())(())(())(())(())(())((
on of Vital Record	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition case referred to medical ner? es 2 No er of Death atural 5 Pending cident investiga lomicide 6 Could no determin filer 1 Certifying ck only 2 Medical E	Hospital: 28a. Date (Mon build be being 28a. Place build physician: To the xaminer: On the b	inth 2 Fete and a tart time of cown eath but not resemble for the cown inpatient 2 of Injury th, Day Year) of Injury - At hing, etc. (Special assist of examination of e	al death 3 death 5 dea	occurred at the	26. Pl. Other: 4 Tipury at Work? Yes 2	ace of Death Nursing Hor Nursing For	24a. Was autop performent of the continuity of t	an 2 No 2 N	Month contribute to t do 3 Prot 4b. Were auto prior to co death? 1 Pes Other (Special courred umber or Rura manner as s	Day Year the cause of death? pably 4 □Unknown pasy findings available mpletion of cause of No ((((()))) ((((()))) (((()))) ((())) ((())) ((())) ((())) (())
After this certificate has been structured ding Physician: The law requiremental director, page 2 should lion; To Be Completed	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition case referred to medical ner? es 2 No er of Death atural 5 Pending cident investiga lomicide 6 Could no determin filer 1 Certifying ck only 2 Medical E	Hospital: 28a. Date (Mon build be being 28a. Place build physician: To the xaminer: On the b	inth 2 Feta hant at time of cown eath but not resemble for the cown inpatient 2 of Injury (and injury the country) of Injury - At hing, etc. (Special seeds of my known be best of my known hand in the country in th	al death 3 death 5 dea	occurred at the estigation, in m	26. Pl. Other: 4 Tipury at Work? Yes 2	ace of Death Nursing Hor No T	24a. Was autop performence of the control of the co	an 2 2 No an	Month contribute to t do 3 Prot 4b. Were auto prior to co death? 1 Pes Other (Special courred umber or Rura manner as s	tated.
Division of Vital Record The Hospital or Attending Physician: The law requires the Funaral Director: After this certificate has been speleally filled in by the funeral director, page 2 should be completed to the completed of th	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition case referred to medical ner? es 2 No er of Death atural 5 Pending coldent investiga coldent determinent filer 1 Certifying 2 Medical Ex	Hospital: 28a. Date (Mon build be being 28a. Place build physician: To the xaminer: On the b	inth 2 Fete and a tart time of cown eath but not resemble for the cown inpatient 2 of Injury th, Day Year) of Injury - At hing, etc. (Special assist of examination of e	al death 3 death 5 dea	t 3 DOA 28c. In peet, factory, officerstigation, in m	26. Pl. 26. Pl. Other: 4 — hiury at Work? Yes 2 2	ace of Death Nursing Hor No T	24a. Was autop performence of the control of the co	an 2 2 No 2	Month contribute to to the autoprior to codeath? 1 Yes Other (Special Courred Course Courred Course Co	Day Year the cause of death? pably 4 □Unknown pay findings available mpletion of cause of No No (((()))(())(())(())(())(())(())(())((
Division of Vital Record To the Hospital or Attending Physician: The law required to the Funaral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should Medical Certification: To Be Completed Second Se	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition case referred to medical ner? es 2 No er of Death atural 5 Pending coldent investiga coldent determinent filer 1 Certifying 2 Medical Ex	Hospital: 28a. Date tition by the led the pand man and man an	inpatient 2 Fete form own seath but not resident at time of cown seath but not resident at the form of Injury th, Day Year) of Injury - At hing, etc. (Special seats of examinating stated.	al death 3 death 5 death 6 dea	t 3 DOA 28c. If pet, factory, officestigation, in m 29c. Lice	26. Pl. Other: 4 — hiury at Nork? Tes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ace of Death Nursing Hor No No 2 and place, a death occurre	24a. Was autor performence of the continuous	an 2 No 2 Say med? 2 No 2 N	Month contribute to to the second of the course of the co	be cause of death? be be cause of death? be be death? be be death? be death. be dea
Division of Vital Record To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funaral Director: After this certificate has been seem seempletely filled in by the funeral director, page 2 should be a seen seempletely filled in by the funeral director, page 2 should be a seen seen seempletely filled in by the funeral director, page 2 should be a seempletely filled in by the funeral director, page 2 should be a seempletely seempletel	decedent pregnant e past 12 months? Yes 2 No Unknown her significant condition her significant c	Hospital: 28a. Date tition At be led Physician: To the xaminer: On the b and man And completed caus A. Traw	inpatient 2 Fete form own seath but not resident patient 2 of Injury th, Day Year) of Injury - At hing, etc. (Special seats of examination of death (Iter seats) for death (Iter seats) of death (Iter seats)	BER/Outpatien BER/Outpatien 28b. Time of Injury 4'05 ome, farm, stre bowledge, death ation and/or inv	t 3 DOA 28c. In P M 1 coccurred at the restigation, in m	26. Pl. Other: 4 — hiury at Nork? Tes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ace of Death Nursing Hor No No 2 and place, a death occurre	24a. Was autor performence of the continuous	an 2 No 2 Say med? 2 No 2 N	Month contribute to to the second of the course of the co	be cause of death? be be cause of death? be be death? be be death? be death. be dea

			For State Registrar	State of M	arylan	-	artmen rtificat			ind Me		giene Reg. Na	2005	15255
	Physici		1. Decedent's Name (First, Middle,		orrec	CO					2. Date of Dea	ath		3. Time of Death 6:25a
	/Medio Examir		4a. Facility Name (If not institution, 10609 Belfas	give street and number,				Town, or	Location of	f Death		4c.	County of Death	
	Funeral Director		5. Social Security Number 130-16-5891 Usual Residence of Decedent	5. Sex 1 □ M 2 🔀 F	ge (In yrs. 79	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Day 8/21/	v. Year)	9. Birthy Cou. 5 Broo	place (State or Foreign orty) oklyn, NY
	Maryland a-f show	tor	10a. State 10b. County	gomery		y. Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28	ai Dire	10e. Street and Number 10609 Belfast	Place			10f. Zip	Code 2085	4			10g. Citi	zen of What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, If a Madical Examination is be malified at 000s.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' d 1 Yes 2 If Yes, Give Year or Dates:	?		Was Deced f Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spec , Puerto R	ify Yes or No- ican, etc.)		14. Race - Americ Black, White, Specify:	
21215-0036	i within 72 ho pene. r than "natu Ine Madical	ompieted	15. Decedent's (Specify onfy highest Elementary/Secondary (0-12)		5+)		dent's Usua kind of wor DO NOT us giste	k done d e retired)	uning most		7	16b. Ki	nd of Business/In	
Maryland 2	should be filed nd Mental Hyg marked othe Imatic event,	To Be C	17. Father's Name (First, Middle, L. John T. Daly	ast)							First, Middle, Glover		Sumame)	
	and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationshi			106	09 Be	elfa					Town, State, Zip , Md 20	
Baltimore,	Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Special Content of the Content of	ecity)		Place of Dispo- emetery, cren hesapo			m. 5	Da 705/			cation - City or To	
Ba	permit. Departn Imports any inju		21. Signatur of ineral Service Li	worth.	4.154	9:	241 (Colu	mbia	Bly	d.Sil	ver	SERVIC Sprin	g,Md20910
	Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nry one cause on each I	ne. 7 ST	ATIC			C N			rest,		Approximate Interval Between Onset and Death
8760,	eate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequ	uence ofji								
.O. Box 687	The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal	I death 3	Ectopic pre				7.	2	23d. Date of delive Month	ery Day Year
s, D	w requires that been signed b should be deta	by	Part II. Other significant condition ALZHEIM	s contributing to death to	out not resu	ulting in the un	nderlying ca	iuse givei	n in Part I.		23e. Did to		m ²	ne cause of death?
al Reco	: The law recate has be page 2 sho	Completed									24a. Was a autop: perfor	sy	24b. Were auto prior to cor death? 1 \(\subseteq \text{Yes} \)	psy findings available mpletion of cause of
Division of Vital Record	iding Physician: The lar th. After this certificate has funeral director, page 2	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	Hospital: 1 Inpatii 28a. Date of Inju	iry	ER/Outpation 28b. Time of Injury		Cther Sc. Injury Work	4 □ Nur	sing Home	Check only or 5 ☑ Resid d. Describe h	ence 6	i □Other (Specify coccurred	v)
Divis	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could no determin	t be			eet, factory,	office		28	f. Location (S City or Tow		Number or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	(Check only 2 Medicel E:	Physician: To the best caminer: On the basis of and manner st	f examinat	wledge, death tion and/or inv	restigation,	in my opi	nion, death	place, an occurred	d due to the c at the time, d	ause(s) late and	and manner as st place, and due to	ated. the cause(s)
}	with To	2	29b. Signature and title of certifier	en			290.	License	number	7	2	9d. Date خ خ	signed (Month,	Day, Year)
	h		30. Name and address of person w		death (Item	(1)		10	26	KA	MAN	P	MD.	
ŀ	Sta Registr		31. Date filed (Month, Day, Year)	2. Registr	rar's Signa	ture	the same	ILLE	- /	41)		1 .	- 0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret M. Pheips 10=12 A M May 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore NIA University of Manyland Medical 8. Date of Birth (Month, Day, Year) Sept. 17 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 80 579-20-9751 Director 1924 D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other treumatic event, the Medical Examiner must be notified at by Funeral Director Glen Burnie 1 ☐ Yes 2X No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e or 21060 622 Opel Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "neturel", or 1 ☐ Yes 2 ☒ No Specify Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin George Victoria ဂ္ Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley W. Phelps Sr. (spouse) 622 Opel Road, Glen Burnie, MD 21060 If item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 05 20a. Method of Disposition 20c. Location - City or Town, State May 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2005 Baltimore, Maryland 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Parti. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) intarchon Pnysician Mvocardial /Medical Due to (or as a consequence of) Examiner arten bronary Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physicien detached tor use as the burial P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 PNo 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours a To the Funerel C 12 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 May 4 2005 person who completed cause of death (Item 23a) (Type, Print) UMMS 29 S. GREENE ST BALTIMORE NO 2120 1 32 egistrar's Signature 31. Date filed (Month, Day, Year) State 05 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:45 PM 2005 30 Pruski April Bertha Anna /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Millenium Nursing Home Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 12,1920 Birthplace (State or Foreign Country)
 MI) 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 反 F 85 Director 215-01-3481 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or iteme 23s or 28s-f show the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Harford Street 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3945 Old Rocks Road 21154 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Mad Elementary/Secondary (0-12) College (1-4or 5+) Publishing Book Binder 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental I and: If item 27 is marked o Rudolph Montier Louise Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3945 Old Rocks Road, Street, MD 21154 Mrs. Barbara Reph / daughter other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

1 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: If any injury or Cedar Hill Cemetery May 4, 2005 Brooklyn, MD Service Censee 21. Signatur 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 Mollas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death n colate Cause (Final mase or condition sulting in death) Pnysician MYOMIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician a Box 68760, Physician/Medical attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 ☐ Probably ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation M 1 Tes 2 No death. 2 Accident Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dira Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ag d title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste. 231 Annapolis, MD. 21401 ADITYA CHOPKA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 05

ORIGINAL

		State Registrar			artment of F rtificate of	Death	F	Reg. No. 2	0.5	1525
ysicia	ın	Decedent's Name (First, Middle, La.			-		2. Date of Dea Month	Day	Year	3. Time of Death
Nedic	al .	William Alfr			# 05 To	.1	April		005	9:25 p M
amin	er	4a. Facility Name (If not institution, give		or)		r Location of Dea	th	4c. County		. 1. 1
eral		Millenium Nursin 5. Social Security Number 6. S		Age (In yrs. last birthday	Glen Bi	If Under 24 Hrs	8. Date of Birt		9. Birthpl	NGEL lace (State or Foreign itry)
ctor		220-12-5373	M 2□F	79 Yrs.	Months Days	Hours Min	8. Date of Birtl (Month, Day Sept. 2	4,1925	MD Coun	itry)
43521	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	anation.				140	0d. Inside City Limits
Ta Die	5								'	1 Yes 2 No
alle	ect	MD Anne A	rundel	Glen B	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citizen of V	What Coun	
event, the Madical Examiner must be notified at		702 Marlboro Roa	d			.061			S.A.	
	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.	Was Decedent of H		Specify Yes or No-		e · America	
	E	1 Never Married 2 Married	Armed Force 1 Yes 2[If Yes, Give Year or Date	XNo	1 ☐ Yes 2 No		to Hican, etc.)		ck, White, e	
	d by	3 Widowed 4 Divorced	1					Specify	WII	nite
	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	orking	16b. Kind of Bu	usiness/Ind	fustry
	E C	Elementary/Secondary (0-12)	Coilege (1-4d	r5+)	Metal Co			Sheet	Meta	1
	Be Co	17. Father's Name (First, Middle, Last)			110001		me (First, Middle,			<u></u>
	To B	Howard Price S	r.			Dora	Bouchet			
		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ng Address (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip	Code)
		Mrs. Bertha A. Pr	ice / wif		Marlboro		en Burni	e, MD 2	1061	
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from Sta	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location -	City or To	wn, State
SING.		4 □ Denation 5 □ Other (Specif		Meadowri	dge Memor			Elkrid		
1		21. Signature of Funeral Service Licer	199	1/1/3 1 / 1	2. Name and Addre		and the same of th			
		Mussell	Me 11		Second A				, MD	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	sed the death. Do not er i line.	ter the mode of dyin	ng, such as cardia	c or respiratory an	rest,		Approximate Interval Between Onset and Death
וי		Immediate Cause (Final disease or condition	a Care	diac t	Wylton	a				Origot and Death
al er		resulting in death)	Due to (or	as a consequence of):	/					
	5	Sequentially list conditions,	b. Dup to fee	as a consequence of,						
	III	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	200 10 (01	20 0 00.100 01)						
1	Examiner	that initiated events resulting in death) Last	C. Due to (or	as a consequence of):				-		
1	call		d							
1	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		□Ectopic pregnancy	,			te of delive	*
	sici	in the past 12 months?		at time of death 5	Other (specify)			Mo	ntn	Day Year
	Physician/Med	9 Unknown	contribution to donat	hut not condition in the	and a bridge and a second	an in Bank	22a Diel to		aibusta ta th	an annual of denth?
	ρ	Part II. Other significant conditions of	onthouting to deat	a but not resulting in the	maenying cause giv	ษาเกษอกโ.		obacco use conti res 2 🗆 No	nbute to th 3 □ Proba	e cause of death? ably 4 Unknown
	eted									
	Completed						24a. Was a autop	sv g	prior to con	osy findings available apletion of cause of
								2 No 1	death?	2□ No
	Be	25. Was case referred to medical examiner?	Hospital:		Oth	ar	ath (Check only 6			
	T. To	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of I	njury 28b. Time	III 3 DOA	4 [X] Nursing	Home 5 ☐ Resid			"
	tior	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year) Injury	Wor	k? Yes 2□No			-	
	Certification:	3 Suicide 6 Could not b	e 28e. Place of	Injury - At home, farm, s			28f. Location (S	Street and Numb	er or Rural	l Route Number,
	Serti	4 Homicide	building,	etc. (Specify)			City or Tow	m, State)		-
	U	29a. Certifier 15. Certifying Ph (Check only 2 Medical Exar	ysician: To the be	st of my knowledge, dea	th occurred at the tin	me, date and plac	e, and due to the o	cause(s) and ma	inner as sta	ated.
		(Chack call) O Blocked Ever	niner: On the basis and manner	of examination and/or i	exestigation, in my o	pinion, death occ	urred at the time, o	date and place,	and due to	the cause(s)
		one)			29c. Licens	e number		29d. Date signed	d (Month, L	Day, Year)
	Medical					-	73			
		one)			D	570Z	8	05-1	クタ・	05
		one)	completed cause of	of death (Item 23a) (Type	Print)	5702	8	05-0	22.	05
)	Medical	29b. Signature and title of certifier 30. Name and address of person who	PAM.D.	600Rd	Print) qely Av	5702 6.54.2	8 231 Anr	05-10	02. s,n	05 ND 21401
Sta	Medical	29b. Signature and title of certifier 30. Name and address of person who all the control of the certifier o	2A, M.D. 32. Reg	of death (Item 23a) (Type	Print) gely Av	5702°	8 231 Anr	05-1	52. S,n	05 10-21401
Completely filled in by the funers	Medical	29b. Signature and title of certifier 30. Name and address of person who	2A, M.D. 32. Regi	600Rd	Print) Gely Av	570Z	8 231 Anr	05-0 napoli	02. s,n	05 ND 21401

			1 - For State Registrar		State of Ma	ıryland			nt of Healt <i>te of Dea</i>		lental Hy	gien Reg. No	_ 0 0	5	15259	
	St		Decedent's Name	(First, Middle, Las	st)						2. Date of De	aath		Vasa	3. Time of Death	_
	Physici /Medic		Berkley		С.			Pro	ctor		April	2 2	7 20	Year 005	1757 ™	A
	Examir			-	street and number)			4b. City	, Town, or Locat	tion of Death		40	. County o	of Death		
			Anne Art 5. Social Security No		ical Cente				napolis		0 D-1- (D)		Anne			
	Funeral Director		214-14-4		M 2□F	88	ast birthday) Yrs.	Months			8. Date of Bi (Month, Di July 2	ay, Year,	16		lace (State or Foreign	n
	ס		Usual Residence of	Decedent							pury 2	, 19	10	Mary	land	
	arylan show	Ļ.	10a. State	10b. County			, Town or Lo							1	Od. Inside City Limits	
	Ba-f	octo	MD	Anne Aru	indel	S	hady								1 Tyes 2 No	,
	with the	Funeral Director	10e. Street and Nun		n Dand			10f. Zi	p Code	,		10g. Ci	tizen of W		try?	
	eath	erai	11. Marital Status	ug Harbor	12. Was Decedent B	ver in U.S	S 13	Was Dece	2076		ecify Ves or N	2-	USA 14. Race		an Indian	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Enerth with rinal be inclined at ODGs.			ed 2M Married 4 □ Divorced	Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:				edent of Hispanic ecify Cuban, Mes 2 No Spe		Rican, etc.)			, White,		
5-0	72 ho	Completed by	(Spec	15. Decedent's Ed	ducation de completed)		16a. Dece	dent's Usu	ual Occupation	most of work	ina	16b. F	(ind of Bus	iness/Ind	lustry	
21	ithin ne.	mple	Elementary/Secon		College (1-4or 5	+)			ork done during use retired)	most or work	g					
	iled w Hygiei ther ti	Ö	17. Father's Name (First Middle Last			Water	rman	10 1	Anthor's Norm	e (First, Middle		ricul			_
anc	d be f antal h red of) Be		W. Procto					10. 14	Ida I		, маюн	1 Surname))		
Maryland	should b nd Ments marked imatic e	은	19a, Informant's Na				19b. Maili	ing Addres	s (Street and Nu			er, City	or Town. S	State. Zip	Code)	_
	alth a		Doris Pr	roctor (W	ife)				Harbor							
ore,	of He		20a. Method of Disp		ID	20b. Pl			me of other place)		Date		ocation - C			
<u><u>Ĕ</u></u>	Page ment ant: It		`4 □Donation	5 ☐ Other (Specif	Removal from State y)		tro Ci			5/2/	2005	Ва	ltimo	re,	MD	
Baltimore,	permit. Departe Import any Inj		21. Signature of Fu	neral Service Con	see		2	Hard	nd Address of F esty Fu idgely	neral	Home, I	P.A.				
			23a. Part1, Enter the shock, or hear	ne disease, or com it failure. List only	plications that caused one cause on each lin	the death	. Do not en	ter the mo	de of dying, sucl	h as cardiac	or respiratory a	rrest,	 		Approximate Interval Between	
	Physician		Immediate Cause (disease or condition	Final	Coror	ary	Art	Ton C) is ease						Onset and Death	
	/Medical Examiner		resulting in death)		Due to (or as a	consequ									112	_
н	LAGIIIIIO	<u>.</u>	Sequentially list con	nditions,	b. Due to (or as a	2 00000000	- O				· · · · · · · · · · · · · · · · · · ·					
.7	ted nslt	nine	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	rlying injury	Due to (or as a	a consequ	ence or):									
Y	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) L	ast	C. Due to (or as a	a consequ	ence of):									
68760,	sicia sicia e buri	edicai I		l	d											
	= 00 6		15.55144.6													
Вох	eath cert attendin	an/k	IF FEMALE: 23b. Was decedent in the past 12		23c. If yes, outcome	of pregnar 2 Fetal		□Ectopic p	regnancy				23d. Date		*	
	requires that the death cert een signed by the attendin hould be detached for use	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant at 9□ Unknown	time of de	ath 5	Other (s)	pecify)				Mont	ın	Day Year	
P.O.	w requires that the de been signed by the should be detached			icant conditions	ontributing to death bu	it not resu	ilting in the u	ınderivina (cause given in P	Part I	23e. Did	tohacco	use contrib	oute to th	e cause of death?	
Records,	uires sign	Completed by	Den	entra			•	, ,	3 · · · · · · · ·						ably 4 Unknown	1
200		iete	Hun	entensin	> A						24a. Was	an	24h W	ere autor	sy findings available	
Re	The law ate has b page 2 s	omp	1.16	7							auto perfe	psy omed?	pr de	ior to con eath?	pletion of cause of	
Vital	10 11	e	25. Was case refer	red to medical					26. P	Place of Deat	1 ☐ Yes		11	Yes	2 LI No	_
∫ \	> 01 0	To B	examiner? 1 ☐ Yes 2 📆	No	Hospital: 1 Inpatie	nt 2 🗆 E	ER/Outpatie	nt 31⁄2 D	OA Other: 4	Nursing Ho	me 5 Res	idence	6 ☐ Other	(Specify)	
n o	fter		27. Manner of Death 1 Natural	h 5 🗍 Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe	how inju	ry occurre	d		
sio	Attending r death. ector: After you the fune	cati	2 ☐ Accident 3 ☐ Suicide	investigation				М	1 Tes	2 No						
Division of	or All	Certification:	4 Homicide	determined	28e. Place of Inju building, etc	iry - At hoi :. (Specify	me, farm, st	reet, factor	y, office		City or To	Street al	nd Numbei e)	r or Rurai	Route Number,	
_	spital		29a. Certifier	12 Certifying Ph	ysicien: To the best of	of my know	viedoe deat	th occurred	at the time dat	e and place	and due to the	Cause/a) and man	ner ac co	ated	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		2 Medical Exar	niner: On the basis of and manner sta	examinati	ion and/or in	rvestigation	n, in my opinion,	death occur	red at the time,	date an	d place, ar	nd due to	the cause(s)	
	To the To the comp	Me	29b. Signature and	title of certifier				1	c. License numb				ite signed			_
)			► Wa	yne !	Just _	-		1	03850	63		Bp	il 2	8,2	005	
	2		30. Name and address	ess of person who	completed cause of de	ath (Item	23a) (Type,	Print)	le Road	Wis	+ Rive	1	mp	20.	778	
	Sta		31. Date filed (Mon	th, Day, Year)	22. Registra	r's Signat	ure Son	4						***************************************		_
	Regist	ar	M/	HY O D YOU	SO PERSONAL PROPERTY OF THE PARTY OF THE PAR		-	4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Elizabeth S. a M Ouick April 28 2005 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 St. Andrews Drive Severna Park <u>Anne</u> Arunde1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 27,1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Months 81 Director 578-36-6725 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10b. Count 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits MD 1 ☐ Yes 2 ☐ No Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21401 Funeral 1164 Southview Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 X No 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Yas Giva White 3 X Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Elburn Burroughs Sally C. Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 441 Valletta Court, Punta Gorda, FL 33950 Sandra Miskell (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State important: if it any injury or o 1XXBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 5/2/2005 Crownsville, MD 21. Signature of Funeral Service Lice 6 ee 22. Name and Address of Facility HardestyFuneral Home, P.A. 12 Ridgely Avenue, Appapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final adenocavinoma Drimary UNKNOWN Physician 14005 /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (bries a consequence of): Examiner The law requires that the death certificate be executed burial-transil the attending physicien and Due to (or as a consequence of) Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 20 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificete 1 Yes 1 ☐ Yes 2 ☐ No 2 **X**No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Downley) Other: 4 Nursing Home 5 Residence 6 Kiner (Specify) NOUSS Hospital: 2 1 ☐ Yes 2 ◯ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cai (Check only one) 29b. Signature and tyte of certifie 29c. License number 29d. Date signed (Month, Day, Year) sloull, 4/29/2005

State Registrar SNaut

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

a00 Bestrate

Aunapolis,

Md.

30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print)

Celouich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend/unpend 1tem#2,23a,27,28a-f, perMI), (3845,7/21/05) State of Maryland / Department of Health and Mental Hygiene

	•	State Registrar		r. permb. 6845 , //21 artment of Health and rtificate of Death	Mental Hygier Reg. 1	
		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 16:42 D
Physicia /Medic		Hermes Thomas Raf	ailides		MAY 1	, 2005 7:00p. м
Examin	er	4a. Facility Name (If not institution, give street a. 2327 BOSTON STREET UN]		4b. City, Town, or Location of Deat BALTIMORE	h	4c. County of Death N/A
Funeral Director		5. Social Security Number 6. Sex 1 M M 2 E	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Yea	ar) 9. Birthplace (State or Foreign Country) L969 Maryland
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
a-f show	ctor	Md. N/A	Ba 1	timore City		1X∑Yes 2 □ No
ith the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
ath w		2327 Boston Street		21224		USA
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23e or 28e-f show int, the Macical Examiner must be nuttled at	by Funeral	1 Never Married 2 Married 1 If Y	Yes 2X No	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
hin 72 hou e. an "natura Madical E		15. Decedent's Education (Specify only highest grade comp	leted) (Give	dent's Usual Occupation	rking 16b.	. Kind of Business/Industry
filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	DO NOT use retired) perty Manager		Real Estate Developement
nd 2 should be filed Ith and Mental Hygis 27 is markad other traumatic evant, II	To Be	17. Father's Name (First, Middle, Last) Thomas Rafail		Ma	me <i>(First, Middle, Maid</i> ria Sfakiy	/anudis
and and sm		19a. Informant's Name/Relationship (Type, Pri		ng Address (Street and Number or R		, , , , , , , , , , , , , , , , , , , ,
of Hea		Mr. Ernie Rafailides/B 20a. Method of Disposition 1	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place)	Date 20c.	nore, Maryland 2120 Location - City or Town, State
		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licep\$ee /		trios Cemetery 5/ 2. Name and Address of Facility R		Hill, Maryland Funeral Home, Inc.
permit. Departr Imports any Inju		I muchael f 1	Zuesf 1	1050 York Road T	owson, Mary	/land 21204
Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not en e on each line. tiple Stab and		c or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner		resutting in death)	due to (or as a consequence of):			
ted	Examiner	cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence of):			
siclen and burial-transit		that initiated events c.	due to (or as a consequence of):			
ifficate I g physi as the b	ledical	0				
he death certificate be executed the attending physiclen and shed for use as the burial-transit	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
requires that the d een signed by the hould be detached	by	Part II. Other significant conditions contributing	ng to death but not resulting in the u	underlying cause given in Part I.		to use contribute to the cause of death? 2 No 3 Probably 4 Unknown
elaw hasb je 2 sl	Completed				24a. Was an autopsy performed	
aician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			ath (Check only one)	X -
S S	2	1 XYes 2 No Hospita	1 Inpatient 2 ENOutpatie			6XOther (Specify)SCENE
Jing After fune	Certification:	2 Accident investigation 5-	Date of Injury 28b. Time of Injury 1-1-05 unk	of 28c. Injury at Work? M 1 ☐ Yes 2 XNo	Subject himself	stabbed and cut
i Si te	Certifle	3 Suicide 6 Could not be determined 28e	. Place of Injury - At home, farm, st building, etc. (Specify) residence	treet, factory, office	2327 Bost	e and Number or Rural Route Number, tate) on St., Unit 4 Maryland
To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2X Medical Examiner: O	To the best of my knowledge, dear the basis of examination and/or in d manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occurred.	e, and due to the cause	e(s) and manner as stated.
To tha within 2 To tha complei	W	29b. Signature and title of certifier		29c. License number OCME		Date signed (Month, Day, Year)
		30. Name and address of person who complete	* **		MAY	2, 2005
		LING LI, m	>	111 Penn Street	Baltimore	, Maryland 21201
Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 5 2005	32. Registrar's Signature			

			1 - For State Registrar	tate of Maryland		rtment of Hetificate of L			ene	
í	Physici		Decedent's Name (First, Middle, Last) Frank Ru	onik				2. Date of Death	2 ³ , 200 ⁵	3 Time of Death 2 4:25p M
į	/Medic Examin		4a. Facility Name (If not institution, give stre Holy Cross Hosp:	ital			Sprin	g	4c. County of D Montgo	mery
	Funeral Director		5. Social Security Number 230-56-1815 Sex William Musual Residence of Decedent	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 10/11/		Birthplace (State or Foreign Country) lovenia
Iryland Z1Z15-0030	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. s marked other then "neturel", or Items 23a or 28a-f show umatic event, tre Madical Existing and the halffied at	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educati (Specify only highest grade co	Was Decedent Ever in U.S. Armed Forces? I \(\superset \) Yes \(2 \superset \) No if Yes, Give Year or Dates: on \(\superset \) propileted) College (1-4or 5+)	13. V li 16a. Decec (Give life. L C	Spring 10f. Zip Code 2090 Vas Decedent of His Yes, specify Cubar Yes 242 No lent's Usual Occupa kind of work done d OO NOT use retired) arpenter	spanic Origin? (S b, Mexican, Puerton Specify: tion tion furing most of wor 18. Mother's Nam Gius	becify Yes or No- Decify Yes o	Black, W Specify: 16b. Kind of Busine Constr faiden Sumame) Pislia	merican Indian, Thite, etc. White ss/Industry uction
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 le marke any injury or other treumatic <u>QDG</u> 8.		Paul W. Dennis/Net 20a. Method of Disposition 1 Burial 2 Decremation 3 Rem 4 Donation 5 Other (Specify) 21. Signature Pureral Service Licence	20b. Plac	694 ce of Disponetery, crent lesap	Samuels sition (Name of natory or other place) eake Cre Name and Address HILTP	sen Ct. 5/0 RIWALD	Winter 0/05 I FUNER	Spring Oc. Location - City Beltsvi AL SERV	s,Fla.32708 or Town, State
	American with the prior of the	dicai Examiner	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate eaues. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last d	Acute Myoc Due to (or as a conseque Congestive Due to (or as a conseque Congestive Due to (or as a conseque	Do not enteredicandiance of): ence of): Hea	er the mode of dying	, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death day day day
O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ecords, P.	The law requires that ite has been signed b yage 2 should be deta	b	Part II. Other significant conditions contrib	outing to death but not result	ing in the u	nderlying cause give	n in Part I.			e to the cause of death? Probably 4 Munknown
r	<i>ca</i> —	Completed						24a. Was ar autops perform 1 Yes 2	No 1 1	autopsy findings available to completion of cause of ? es 2 No
ion of Vital	ling Phys	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 inpatient 2 in Et	R/Outpatien 8b. Time of Injury	28c. Injury Work	r: 4 🗌 Nursing H	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 Other (S	(pecify)
Division	tel or Attendi rs after death. el Director: A ed in by the fu	Certification;	a Could not be	28e. Płace of Injury - At hom building, etc. (Specify)	ie, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	Medicai	(Check only 2 Medical Examiner one)	en: To the best of my knowl : On the basis of examinatio and manner stated.	ledge, death on and/or in	estigation, in my op	inion, death occu	rred at the time, da	ite and place, and o	due to the cause(s)
offe-	5 W. Y.		29b. Signature and title of certifier A, Naw			29c. License			Od. Date signed (Mo	
	10		30. Name and address of person who comp A HMED WAW.		Po Be	Print) SX 83	819 E	railhe	isbur	g mo 20883
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 5 2005	DOZ. Hegistrar's Signatu	Spec	(i)				

		-	For State Registrar	State of Ma	aryland / Depa	artment of H rtificate of L		Re	g. No.2	Control Line	15263
	Physicia		1. Decedent's Name (First, Middle, Last, Theodore	Right	nyre			2. Date of Death	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County		
	Funeral Director		132-19-1011	x 7. Ag	e (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 29	,1926	9. Birthp Coun New	lace (State or Foreign try) York
	ne Maryland 8e-f show Alified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	re	10c. City, Town or Lo	imore				1	0d. Inside City Limits 1 ☐ Yes 2 점 No
	th with the 23a or 2	Funeral Director	10e. Street and Number 1561 Clairidge R	oad		10f. Zip Code	1207	10	Og. Citizen of W	/hat Coun	itry?
980	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel; or items 23a or 28e-f ehow event, the Medical Eractifier must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		k, White,	an Indian, etc. nite
Maryland 21215-0036	within 72 ho ene. then "netur re Medicel	Completed	15. Decedent's Edit (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wor	king	Sale		dustry
yland 2	2 should be filed withir and Mental Hygiene. Is marked other then eumetic event, the Ms	To Be Co	17. Father's Name (First, Middle, Last) Barney Rightmyre	L		alesman	18. Mother's Nam	ne (First, Middle, M La Unkno	faiden Sumami		
	is 1 and 2 sho of Health and item 27 is my other treum		19a. Informant's Name/Relationship (T) Sally Giles Right			ng Address <i>(Street a</i> Clairide		ral Route Number, Baltimor			Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other treumetic es ance.		20a. Method of Disposition 1 ── Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Onation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispondermetery, cre Garrison	sition (Name of matory or other place) Forest	9)	Date 2	Owings	City or To	
Balt	permit. Departr imports any inj	1	21. Signature of Funeral Service Licens	Dish	marker 1	2. Name and Addres Vitzke Fun 630 Edmon	s of Facility Leral Hom Ldson Ave	ne of Cat enue Cato	onsvill nsville	e, I	nc 21228
8760, <	Physician death certificate be executed for the estimate of attending physicien and for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or comb shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. — Due to (or as c.	a consequence of): a consequence of): a consequence of):						Interval Between Onset and Death
O. Box 6	death certiff e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor		ory Day Year
rds, P.	signé signé d be	by	Part II. Other significant conditions co	ntributing to death b	out not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob		-	ne cause of death? ably 4 Unknown
Vital Record	The law ate has b page 2 s	Completed						24a. Was ar autops perform 1 Yes 2	ned?		psy findings available inpletion of cause of
o	Attending Physicien: Tordeath. ector: Atter this certificat by the funeral director, pr	ation; To Be	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 1 (24) Thipatie 28a. Date of Inju (Month, Da		f 28c. Injury Work	er: 4 🗌 Nursing H	ome 5 Reside	nce 6 Othe		<i>(</i>)
Division	i Zi fe	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Sti City or Town		er or Rura	l Route Number,
	the Ho tin 24 h the Fui	edical	(Check only 2 Medical Exam	rsician: To the best iner: On the basis o and manner st	of my knowledge, dea if examination and/or in ated.	ivestigation, in my of	oinion, death occu	rred at the time, da	ite and place, a	ind due to	the cause(s)
)	To To com	Σ	29b. Signature and title of certifier	Com	A, MD	29c. License			od. Date signed		
	5	12	2000 /11	ompleted cause of d	H, M) Jeath (Item 23a) (Type FINNORE	Print)	Sa Hiris	ore, UR	21	122	3
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 5	32. Region	rar's Signature	Laure .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Madalyn Reich $p^{\,\mathsf{M}}$ May 1 2005 7:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 311 Riding Ridge Road Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2XX **Director** 82 291<u>-18-3095</u> Mar. 18, 1923 Ohio Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f show the Medical Examinar must be nealfied at Completed by Funeral Director MD 1 ☐ Yes 2XXXVo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Riding Ridge Road 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White 3 Widowed 4 □ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Buyer Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental H litem 27 is marked ott rother treumstic even Be Abraham Zindell Emily Luft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Poldmae Grand Daughter 311 Riding Ridge Road Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ŏ = 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State May 4,2005 permit. Page Department of Important: if any injury of once. Columbus, Ohio * 4 ☐ Donation 5 ☐ Other (Specify) Forest Lawn 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Tatrich 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CLIOBLATIONA Mus - Orus /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-t Due to (or as a consequence of): Box 68760. IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed2 certificete 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOJ 5 / May 2 2005 30. Name and address of person ted cause of death (Item 23a) (Type, Print) Anthony Caputo, MD 139 Old Solomons Island Road, Annapolis, MD 21401 Registrar's Signature State Registrar

		1 - For State Amend Ite			artment of Health and Historicate of Death	Mental Hyg		15265
O. District		1. Decedent's Name (First, Mic	Idle, Last)			2. Date of Deat		3. Time of Death
Physic /Med		George	James	Si	ngle	MAY	$\overset{\text{Day}}{4}$, $2\overset{\text{Year}}{005}$	9:50A M
Exam		4a, Facility Name (If not institut	ion, give street and number)		4b. City, Town, or Location of Dea	ith	4c. County of Death	1
		1228 HESSE A	VENUE		ROSEDALE		BALTIM	MORE
Funera		5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	0.8:	place (State or Foreign
Directo		191-10-6205	1 □ M 2 □ F	88 ^{Yrs.}	Months Days Hours Mir	1. (Month, Day, 2-28-19	17 PENI	NSYLVANIA
p		Usual Residence of Decedent						1011111111
rylar how		10a. State 10b. Coun	TIMORE	10c. City, Town or Lo			1	0d. Inside City Limits
e-f s	5		TITIONE		ROSEDALE			1 ☐ Yes 2 No
다 다 or 28	Funeral Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Cour	ntry?
ih wi 23a 191 b	<u>a</u>	1228 HESSE	AVENUE		21237		U.S.A	A.
deat	ner	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ	an Indian,
or Ita	교	1 Never Married 2 M		No		no Hican, etc.)	Black, White,	etc.
O3	þ	3X Widowed 4 □ Divorce	ed If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No Specify:		Specify: W	HITE
21215-0036 of within 72 hours after death with the Maryland righene. Then "natural", or Itams 23a or 28e-f show in the martical Evand her must be notified at	Completed	15. Deced	ent's Education hest grade completed)	16a. Dece	dent's Usual Occupation	1	6b. Kind of Business/Inc	dustry
within within then then were	pje				kind of work done during most of w DO NOT use retired)	orking		
	Ö	Elementary/Secondary (0-12 12			CARPENTER		BETHLEHAM	STEEL
	Be (17. Father's Name (First, Middl	e, Last)		18. Mother's Na	ime (First, Middle, M	laiden Sumame)	
arylar should be nd Menta marked umartic ev	To	JOHN	SINGLE JOHN	SINGEL	ANNA	(LASKO))	
Maryland of 2 should be fliv th and Mental Hy 27 is marked oth traumatic evani		19a. Informant's Name/Relatio	nship (Type, Print)	19b. Mailir	ng Address (Street and Number or F			Code)
- 4		CAROLE MCATE	ER/ DAUGHTER	1151	1 SHERWOOD ROAD	UPPER FA	LLS, MD 2	1156
- T 40 -		20a. Method of Disposition	n 3 □Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)	Date 2	0c. Location - City or To	wn, State
Pages nent of int: if it		`4 □Donation 5 🙀Other	(Specify) FOTOMPATE OF	1	F FAITH CEM MAY	9. 2005	BALTIMORE.	MD
Baltim permit. Pag Department Important: any injury o		21. Signature of Funeral Service			. Name and Address of Facility C	ACH/ROSED	ALE FUNERAL	HOME
Demi Permi Depa Impo	4	10	2		211 CHESACO AVEN			1237
		23a. Part1. Enter the disease,	or complications that caused	the death. Do not ent	er the mode of dying, such as cardia		•	Approximate
Discontinue	ı.	Immediate Cause (Final	ist only one cause on each li	ne.	Pond D-	1		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	a consequence of):	rever to	1 ure		3-4 w/cs
Examiner			Duo to (or as	a consequence or,	1			
N SHI	e le	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):				
/ bed iso	듣	Cause (Disease or injury	<					
xecu and	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				
8760, sate be executed physician and the burial-transit	icai E							
- 2 > u			d.					
Geath certifica death certifica attending phed for use as the	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				
Box eath cert attending	jan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy		23d. Date of deliver	ry Day Year
P.O.	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time or death 5L	Other (specify)			,
The page		Part II. Other significant condi	itions contributing to death h	ut not resulting in the ur	aderhina cauca gwee in Part I	23a Did tob	acco use contribute to the	a source of death?
Records, Fine law requires that has been signed age 2 should be de	by	I PChemic	1) -	anyto ha	the DAA			abiy 4 Donknown
cord: w require been sign	tec	11-Tal	00000	02	10000	/ 10 705	2 No 3 Proba	abiy 4 Donknown
He law	pje	TIM	, (0	PP.		24a. Was an autopsy	24b. Were autop	sy findings available
	Completed					perform	ed? death?	21 No
Division of Vital F or Attanding Physician: Th after death. Director: After this certificate I in by the funeral director, pag	Be (25. Was case referred to medic examiner?	al		26. Place of De	ath Check on one		
or value of the or value of th	10	1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	t 3 □ DOA Other: 4 □ Nursing I	Home 5 Residen	ce 6 Other (Specify)
ng Pł ng Pł ter tł		27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date of Inju	ry 28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
Vision Attending r death. actor: After	atic		stigation	, roal,	M 1 Yes 2 No			
Vis ratte racte	tific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	d not be rmined 28e. Place of Inj building, et	ury - At home, farm, stre	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural	Route Number,
Div tal or A s after al Dirac	Certification:		building, of	c. (opacity)		City of Yours,	Sialey	
Divisit To the Hospital or Attance within 24 hours after death To the Funeral Director: completely filled in by the	Sai	29a. Certifier 1 Certify	ring Physician: To the best	of my knowledge, death	occurred at the time, date and place	a, and due to the cau	ise(s) and manner as sta	ated.
ha H in 24 ha Fi plete	edicai	one)	al Examiner: On the basis of and manner sta	t examination and/or inv	estigation, in my opinion, death occi-	urred at the time, dat	e and place, and due to	the cause(s)
To tha within 2 To tha complet	Σ	29b. Signature and title of certif			29c. License number	290	d. Date signed (Month, D	Day, Year)
		MIS	MD		D-387	54 1	05-05-	2005
\sim		30. Name and address of perso	on who completed cause of d	eath (Item 23a) (Type.	D-387	2	- 4	2122
U		MALIKA	WASER	M. 7c	9. EASTER	N USLV	D, M-D-	41221
11	ate	31. Date filed (Month, Day, Yea	(r) 32. R 15%	ar's Signature				
Regis	trar	MAY 0	5 2005	w K	C. A.			

			1 - State of Maryland / Dep	artment of Health and Mertificate of Death	, ,	ene . No. 2005 15266
I	Physicia	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death
П	/Medic		Margarita S. Suchorebrow		May	2 2005 2:23A M
Н	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Europel		Harmony Hall 5. Social Security Number 6. Sex / 7. Age (In yrs. last birthda)	Columbia) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Howard 9. Birthplace (State or Foreign
	Funeral Director		028-38-1493 1□M 2NF 87 Yrs.	Months Days Hours Min.	Oct. 10,	ear) Country)
	P .		Usual Residence of Decedent			
	arylar show	-	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits 1 ☐ Yes 2X No
	Ne M	Director	Virginia Frederick Midd	Letown 10f. Zip Code	100	. Citizen of What Country?
	with is or i				100	
	ns 23	Funeral	2155 Massanutten Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13	22645 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	U.S.A. 14. Race - American Indian,
0	w Itar	표	1 Never Married 2 X Married 1 ☐ Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
E E	ral', o	l by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
2-0	72 h 'natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation skind of work done during most of worki	ng 16	b. Kind of Business/Industry
12	within ane. than	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Medicine
מ ם	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "naturel", or lams 23e or 28e-f show event, the Medical Examinet must be notified at		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	
Maryland 21215-0036	ed all	To Be	Boris Toporkoff	Elizah	eth Ward	,
ary	2 should be filed w n and Mental Hygie 1s marked othar ti raumatic evant, ID	_		ling Address (Street and Number or Rura		
Σ	D = C =		Victor Suchorebrow (Son) 5510) Smallwood Court	Clarksvi	11e, MD 21029
ore	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cametery, critical states are considered as a constant of the constant o	osition (Name of Dematory or other place)	Date 20	c. Location - City or Town, State
altimore,	Pages ment of I ant: If ite			sh Crematory 5-6-	2005 1	Laurel, Maryland
Ball	permit. Pages 1 an Depertment of Heal Important: If item 2 any Injury or other once.			^{12.} Name and Address of Facility Vitzke Funeral Home 5555 Twin Knolls Ro	es, Inc.	mbia, MD 21045
	\$		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Interval Retween
	Physician		Immediate Cause (Final disease or condition	s millitus	Cance	Onset and Death
Н	/Medical Examiner		resulting in death) Due to (or as a consequence of)			
	_xammo.	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	5 /1/1/1, rus		
V	rted Insit	nlne	cause. Enter Underlying Cause (Disease or injury	usern		
v	execu in and ial-tra	Examlner	resulting in death) Last Due to (or as a consequence of):	44		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be defached for use as the burial-transit	dlcal	d. Anemi	a		
9	artifica ing ph	a l	IF FEMALE:			
Вох	eath certific attending p	by Physiclan/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year
0	the a	ysic	1 Yes 2 1 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)		
<u>α</u>	res that the de signed by the a be detached f	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Records,	uires n sign lld be	d b			1 🗆 Yes	2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown
00	iw require s been si should b	lete			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
_	The lav	Completed			autopsy performe 1 Yes 2	d? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vita		BeC	25. Was case referred to medical examiner?	26. Place of Death		Accided
<u>~</u>	Physic this ce al dire	To	1 Yes 2 Too Hospital: 1 Inpatient 2 ER/Outpatie		me 5 Residence	ce 6 Dother (Specify) Ling
ū	Attending Pher death. sector: After the by the funeral	on:	27. Manner of Death 1 ☐ Watural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred
Sic	death death stor: , the f	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	20f Location (Stre	et and Number or Rural Route Number,
Division of	lor A after Dirac	Certification:	4 Homicide determined building, etc. (Specify)	treet, ractory, office	City or Town,	
	spita nours neral / fillec		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	and due to the cau	se(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)
	To the To the Complex	Σ	29b. Signature and title of ceptiler	29c. License number	290	Date signed (Month, Day, Year)
			180	1508 10	17	lay and accid
_	2			al Bell lane	Clark	Tay and 2005 sulle MD 21029
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 5 2005 32. Registrar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

	1	- State Registrar	State of Maryland / I	Certificate of Death		Reg. No.	UJ	1020
sician		I. Decedent's Name (First, Middle, Last)			2. Date of D Month	Day	Year	3. Time of Death
edical	١.		Sauer		May 2,			6:15 p
miner	4	la. Facility Name (If not institution, give :	street and number)	4b. City, Town, or Location of E	eath		inty of Death	
77	5	Fair Haven 5. Social Security Number 6. Sex	7. Age (In yrs. last bit	Sykesville	Hrs. 8. Date of Bi		roll	lace (State or Fore
ral tor			M 2X0F 96		May 9,	av Year)	Cour	sylvania
	ı	Jsual Residence of Decedent			1222) 3 9		1	by I valida
To Be Completed by Funeral Director	_ _	10a. State 10b. County	10c. City, Tow				1	0d. Inside City Lim
Funeral Director		Maryland Carroll	Sykesv	111e				1 □ Yes 2 🔼
i	1	IDe. Street and Number		10f. Zip Code		10g. Citizen	of What Cour	ntry?
ia i	5	7200 Third Avenue		21784		United	State	S
Lue	1		12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 	? (Specify Yes or N verto Rican, etc.)	0- 14. F	Race - Americ Black, White,	
by F		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Spe	city: Whi	te
ed	5	15. Decedent's Edu		. Decedent's Usual Occupation		16h Kind of	f Business/Inc	duata.
Completed	<u> </u>	(Specify only highest grade	e completed)	(Give kind of work done during most of life. DO NOT use retired)	working	IBB. KING O	i business/inc	dustry
E	5	Elementary/Secondary (0-12)	College (1-4or 5+)	usewife		Own 1	Home	
BeC		7. Father's Name (First, Middle, Last)			Name (First, Middle	1		
To B		Frank Harrison		Marga	ret McCr	edie		
		19a. Informant's Name/Relationship (Ty	pe, Print) 19b	o. Mailing Address (Street and Number o			wn, State, Zip	Code)
	(Conrad P. Sauer	(Son) 22	6-10 141 Avenue,	Laureltor	, New	York 1	1413
	2	20a. Method of Disposition	aamata	f Disposition (Name of ry, crematory or other place)	Date	20c. Locatio	on - City or To	wn, State
		1X☐ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval mom State		7, 2005	Pittsb	urg. P	ennsvlva
once.	2	21. Signature of Funeral Service License		22. Name and Address of Facility			_	_
once		I Chooxed & Ka	Oner M00333	8728 LibertyRd. 1	Randallst	own,MD	21133-	-4784
er er		resulting in death)	Due to les es e sesses					
cai Examiner		Sequentially list conditions, any leading to an additional acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	pleural effusion				
ledical		resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence Due to (or as a consequence 3c. If yes, outcome of pregnancy 1	of): Of Company Of): 3 Ectopic pregnancy 5 Other (specify)		1	Date of delive Month	ry Day Year
by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	Due to (or as a consequence Due to (or as a consequence 3c. If yes, outcome of pregnancy 1	of): Of Company Of): 3 Ectopic pregnancy 5 Other (specify)	23e. Did	tobacco use co	Month	Day Year
pieted by Physician/Medical		resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence Due to (or as a consequence 3c. If yes, outcome of pregnancy 1	of): Of Company Of): 3 Ectopic pregnancy 5 Other (specify)	1 24a. Was	tobacco use co	Month ontribute to the 3 Proba	Day Year e cause of death? ably 4 Unknot osy findings availanpletion of cause
pleted by Physician/Medical	P P	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	Due to (or as a consequence) Due to (or as a consequence) 3c. If yes, outcome of pregnancy 1	of): Of Correction	24a. Was	Yes 2 No an 248 pry prmed? 2 No	ontribute to the autoprior to condeath?	Day Year e cause of death? ably 4 Unknot osy findings availanpletion of cause
pleted by Physician/Medical	P 2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to for as a consequence Due to for as a consequence Due to for as a consequence Consequence Due to for as a consequence Due to for as a consequence Consequence Due to for as a con	of): Comparison Comparison	24a. Was	Yes 2 No an 24th psy rmed? 2 No one)	Month ontribute to the 3 proba b. Were autoprior to condeath? 1 yes	Day Year e cause of death? ably 4 Unknot osy findings availa npletion of cause 2 No
To Be Completed by Physician/Medical	P 2	Part II. Other significant conditions conditions? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Due to (or as a consequence Pregnancy Consequence	of): Of Correction of the control o	24a. Was auto perfet 1 Yes	Yes 2 No an psy primed? 2 No one) dence 6 C	Month ontribute to the 3 probab. b. Were autoprior to condeath? 1 yes	Day Year e cause of death? ably 4 Unknot osy findings availanpletion of cause 2 No
tion: To Be Completed by Physician/Medical	P 2	PFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) Due to (or as a consequence) 3c. If yes, outcome of pregnancy 1	of): Of Corp. of): 3 Ectopic pregnancy 5 Other (specify) In the underlying cause given in Part I. 26. Place of Other: Other: 4 Nursin Vork? M 1 Yes 2 No	24a. Was auto perfe 1 To Perfe Superior Perfe Superior Su	Yes 2 No an psy primed? 2 No one) dence 6 C	Month ontribute to the 3 probab. b. Were autoprior to condeath? 1 yes	Day Year e cause of death? ably 4 Unknot osy findings availa npletion of cause 2 No
tion: To Be Completed by Physician/Medical	P 2	PEFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence Pregnancy Consequence	of): Of Corp. of): 3 Ectopic pregnancy 5 Other (specify) In the underlying cause given in Part I. 26. Place of Other: Other: 4 Nursin Vork? M 1 Yes 2 No	24a. Was auto perfu 1 Tyes Death (Check only ig Home 5 Resi 28d. Describe	tobacco use co	Month all proba b. Were autopping to condeath? 1 Yes Other (Specify curred	Day Year e cause of death? ably 4 Unknot osy findings availa npletion of cause 2 No
tion: To Be Completed by Physician/Medical	P 2	PERMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence Live birth 2 Fetal death Fregnant at time of death Unknown Stributing to death but not resulting in Dispital: 1 Inpatient 2 ER/OL 28a. Date of Injury (Month, Day Year) 28b. Flace of Injury - At home, fabuilding, etc. (Specify)	of): Colored 24a. Was auto perficience of the control of the con	Yes 2 No an 24t psy 2 No one) dence 6 Chow injury occ Street and Nur wn, State)	Month ontribute to the allowing prior to condeath? 1 Yes Other (Specify curred)	Day Year e cause of death? ably 4 Unknot osy findings availa npletion of cause 2 No	
tion: To Be Completed by Physician/Medical	P 2	PFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Construction of pregnancy Construction	of): Colored 24a. Was auto perful 1 Yes Death (Check only ig Home 5 Resi 28d. Describe 28f. Location (City or To	Ves 2 No an psy primed? 22 No an 24t psy primed? 28 No one) dence 6 □ C how injury occ Street and Nur wn, State)	Month ontribute to the state of the state o	Day Year e cause of death? abily 4 Unkno by findings availa appletion of cause of	
tion; To Be Completed by Physician/Medical	2	### Presulting in death Last ### FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) Due to (or as a consequence) Construction of pregnancy Construction of	of): Color Color Color	24a. Was auto perful 1 Yes Death (Check only ig Home 5 Resi 28d. Describe 28f. Location (City or To	Yes 2 No an psy prmed? 2 No dence 6 C how injury occ Street and Nur wrn, State) cause(s) and a date and place	Month ontribute to the support of condeath? Other (Specify curred) manner as state, and due to	Day Year e cause of death? ably 4 Unknot begindings availa npletion of cause 2 No 1 Route Number, ated. the cause(s)
tion: To Be Completed by Physician/Medical	2	PFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Construction of pregnancy Construction	of): Continued 24a. Was auto perfu for the following Home 5 Resi 28d. Describe 28f. Location (City or To lace, and due to the recurred at the time,	tobacco use co Yes 2 No an psy primed? 22 No dence 6 C how injury occ Street and Nur wm, State) Cause(s) and indate and place 29d. Date sign	Month all Probab b. Were autopyrior to condeath? 1 Yes Other (Specify curred) manner as state, and due to ned (Month, E	Day Year e cause of death? ably 4 Unkno posy findings availa npletion of cause 2 No r) Route Number, ated. the cause(s)	
Certification: To Be Completed by Physician/Medical	2	### Presulting in death Last ### FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Construction of pregnancy Construction	of): Color Color Color	24a. Was auto perfu for the following Home 5 Resi 28d. Describe 28f. Location (City or To lace, and due to the recurred at the time,	Yes 2 No an psy prmed? 2 No dence 6 C how injury occ Street and Nur wrn, State) cause(s) and a date and place	Month all Probab b. Were autopyrior to condeath? 1 Yes Other (Specify curred) manner as state, and due to ned (Month, E	Day Year e cause of death? ably 4 Unknot begindings availa npletion of cause 2 No 1 Route Number, ated. the cause(s)
tion: To Be Completed by Physician/Medical	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	### Presulting in death Last ### FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to for as a consequence Consequence Due to for as a consequence Due to for as a consequence Due to for as a consequence Fetal death Graph Pegnant at time of death Unknown Dispital: 1	of): Color Color Color	24a. Was auto perfu to the cocurred at the time,	tobacco use co Yes 2 No an psy primed? 22 No dence 6 C how injury occ Street and Nur wm, State) Cause(s) and indate and place 29d. Date sign	Month all Probab b. Were autopyrior to condeath? 1 Yes Other (Specify curred) manner as state, and due to ned (Month, E	Day Year e cause of death? ably 4 Unknot be provided in the cause of death?

			1 - For State Registrar	State of N	Maryland / Depa	artment of rtificate of		d Mental H	ygiene Reg. No.	005	15268
	Discontinu		Decedent's Name (First, Middle,	Last)				2. Date of D			3. Time of Death
	Physici /Medio		Leonard Steven T	urner				April	29, 2	Yeer 2005	3:44 PM
>	Examir		4a. Facility Name (If not institution,	give street and numbe	r)	4b. City, Town,	or Location of D	eath		County of Death	3.11
			Southern Marylan	d Hospital		Clinton			Pr	ince Geo	rge's
	Funeral			. Sex 7. /	Age (In yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of B	irth Dav. Year)		place (State or Foreign ntry)
	Director		238-68-5589	MIM 2017	62 Yrs.		1,00,0	Dec. 1	L4, 19	942 Nort	h Carolina
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ontion					104 (
	sho	2									10d. Inside City Limits 1 ☐ Yes 2X No
	788-1	Directo	Maryland Prince 10e. Street and Number	George's	Temple Hi						
	with a series	급				10f. Zip Code				zen of What Cou	•
	s 23	Funeral	4675 Dallas Plac		T. Francis III C	2074				d State	
	ltam Itam	Ľ.	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Deceder Armed Force 1	s?	If Yes, specify Cul	hispanic Origin ban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	10-	 Race - Americ Black, White, 	
21215-0036	172 hours after death with the Maryland "natural", or Itams 23a or 28a-f show close Examinar must be notified at	by F	3 ☐ Widowed 4 🕅 Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 💢 No	Specify:			Specify:	D. 1
Ö	tura tura	ed	15. Decedent's			dent's Usual Occu	ination		16h Kir	nd of Business/In	Black
15		Completed	(Specify only highest	grade completed)	(Give	kind of work done DO NOT use retire	during most of	working	Pret		dustry
12	within lene. r than "	mo	Elementary/Secondary (0-12)	College (1-4o 4	r5+)	ouse For			Manu	facturi	ng
ğ	illed Hygid other ent, I	Be C	17. Father's Name (First, Middle, La	st)	1			Name (First, Middl	e, Maiden .	Sumame)	
<u>a</u>	should be filed withlind Mental Hyglene. marked other than imatic event, the Mental Men		John A. Turner				Dousia	Houne			
Maryland	and Men is marke		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Stree	·	r Rural Route Num	ber, City or	Town, State, Zip	Code)
	12 mg		Henry A. Turner	(Brother)	219	Springfi	eld Rd.	, Statesv	rille.	NC 286	25
Baltimore,			20a. Method of Disposition		20b. Place of Dispo			Date	+	cation - City or To	
9	8 <u>~</u> = 5		1 X Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe		Belmont (1	6, 2005	Stat	ecville	NC
₩.	# Friday		21. Signature of Funeral Service Lic		#CC0321_22	2. Name and Addr	ess of Facility	0, 2005	Stat	CSATITE	, NC
B	per Imp gany gany		Manael	PA 101	#CC0321 2	utledge	& Bighar	n Funeral ., States	Home	NG 20	(77
			23a. Part 1. Enter the disease or co shock, or head failure List or	omplications that caus	ed the death. Do not ent	er the mode of dy	ing, such as car	diac or respiratory	ville arrest.	NC 280	Approximate
	Dhysisian		Immediate Cause Final	lly one cause on each	line.	. 14				4.77	
	Physician /Medical		disease or condition resulting in death)	a. Olla to for	- EXIENS	IVE HE	MORRA	ragic 1-	4~4	calulus	uknow
4	cate be executed XX Canada Payantie and the burial-transit and the b	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	is a consequence of):	f Fai	lme_	_		2	an throw s
687	icate physl s the b	dlc		d							
.O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnanc Other (specify)	; у		2	3d. Date of delive Month	ory Day Year
rds, P.	w requires that been signed t should be det	by	Part II. Other significant conditions	s contributing to death	but not resulting in the u	nderlying cause gr	ven in Part I.				ne cause of death?
Records,	e law re has bed je 2 sho	Completed						24a. Wa	psy	prior to cor	psy findings available mpletion of cause of
		S						1 √Yes	ormed? 2 ☐ No	death2	2 🗆 No
Vital	iclan: certifice ector, p	Be	25. Was case referred to medical examiner?	Hospital:		0	-	Death (Check only	one)		
of	Phys this al dii	2	1 Yes 2 Tho	1 Minpa	The state of the s	I 3 DOA		g Home 5 Res			1)
	ling After unei	lon	1 ■ atural 5 □ Pending	28a. Date of In (Month, E	jury 28b. Time of Injury	Wo		28d. Describe	how injury	occurred	
Sic	Attending r death. sctor: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could not	bo -]Yes 2□No				
É		Certification:	4 Homicide determine	ad 286. Place of I	njury · At home, farm, str etc. <i>(Specily)</i>	eet, factory, office		281. Location City or To	(Street and wn, State)	Number or Rura	i Route Number,
_	Hospitel		29a. Certifier 1 Certifying	District Total							
	To the Hospitei or within 24 hours efte To the Funeral Dir completely filled in	edical	one) 2 Medical Ex	eminer: On the basis and manner:	st of my knowledge, death of examination and/or in- stated.	occurred at the ti	ime, date and pl opinion, death o	ace, and due to the ccurred at the time	cause(s) a , date and p	and manner as st place, and due to	ated. the cause(s)
	To the within 2 To the Complet	Σ	29b. Signature and title of certifier)_		29c. Licen	se number		29d. Date	signed (Month, I	Day, Year)
			an your			504	54		man	7,3,8	25
	3		30. Name and address of person wh	o completed cause of	death (Item 23a) (Type,					11/	
	2		Arastoo Yazdan			vingston	Rd., Ft	. Washin	gton,	MD 2074	+4
	Sta Registr	ite rar	31. Date filed Month, Pay, Year) MAY 0 5	2005 32. Re	trar's Signature	frest					

			1 - For State Registrar	State of M	arylan	d / Depa		of H	ealth a				0.05		15269
	Physici	an	Decedent's Name (First, Middle,	Last)	. /) 1 1 1				2	Date of Dea Month	ath Day	Ye	ar	3. Time of Death
	/Medio	cal	Brenda		Va	llett					May	1	20.		2:12 AM
	Examir	ier	4a. Facility Name (If not institution,	1.1		\ ,	-		Location of			4c.	County of D	eath	
			5. Social Security Number	50Kins 1+0	e (In vrs	last birthday)	If Under 1	1 Year	If Under	24 Hrs. 18	Date of Birt	h	0	Qiethele	Chate of Farrier
	Funeral Director		213-66-2666	1 □ M 2 □XF	49	Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Da)	y, Year) 195			ace (State or Foreign ry)
	P .		Usual Residence of Decedent								u. J,	173	J INI	w <u>ty</u> .	land
	arylar show	_	10a. State 10b. County Maryland Howar	d		y, Town or Lo Cumbia	ocation							10	d. Inside City Limits
	8a-1	Director		и 	Lox	LUMBLA									1 X Yes 2 □ No
	with th	Dir	10e. Street and Number				10f. Zip (zen of What		
	eath	era	9229 Crazy Quil 11. Marital Status	12. Was Decedent	Ever in U	S 13	Vas Decede		spanic Ori	ain? (Speci	ify Vas or No.		ted S.		
(0	riten	Funeral	1 ☐ Never Married 2X Marrie	Armed Forces? ed 1 ☐ Yes 2 🔯		1			n, Mexican	i, Puerto Ri	fy Yes or No- can, etc.)		Black, W		
93	72 hours after death with the Maryland natural', or Hems 23a or 28a-f show Jisal Exactive rousi be redified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	No.	Specify:				Specify:	Whi	te
21215-0036	i within 72 hours after death with the Marylar liene. r than "natural", or Items 23a or 28a-1 show the Medical Executive mast ke cyllified at	Completed	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual kind of work	Occupa	ition	t of working	7	16b. Kir	nd of Busine	ss/Indi	ustry
121	within ene. than "	m	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use	e retired))						
2	Hygiel Hygiel Ather th		12th Grade 17. Father's Name (First, Middle, L	n cet)		Edi	tor		10 11-45-	de Nierre (Ti Middle		ense		
Maryland	ed it a	Be C	Raymond James		T 4						First, Middle.				
7	d 2 should k th and Ment 7 te markac traumatic	2	19a. Informant's Name/Relationsh		J/L.	19b Mailir	ng Address /	(Street a			Hunge Route Numbe			Zin (Code)
Z	ith ar 27 to 1 trau		Charles W. Vall		d						Colum				
ම	s 1 and 2 of Health Item 27		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei				Dat			cation - City		
Baltimore,			1 ☐ Burial 2 💆 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp							/03/0	5	Lau	700 1	นก	
alti	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service L	icensee	1	22	2. Name and	Addres	s of Facility	y Fle	ck Fun	eral	Home	TI	nc.
m	90 5 8 9		ECTY	MOO.	869	76	601 Sa	ndy	Spri	ng Ro	ad, La	urel	, MD.	20	707
U			83a. Part1. Enter the disease, or o shock, or heart ailure. List o Immediate Cause (Enal			n. Do not ent	er the mode	of dying	, such as	cardiac or i	respiratory ar	rest,		í	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease of thion resulting in death)	a. Seps											ac week
1	Examiner			Due to (or as		uence of):	4 4	1	hiaa	0					V
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as			A(C3()	1661	12166	<u> </u>				1	weeks
Y	outed id ansit	Examine	that initiated events	· Coas	utop	athy								th	ree months
oʻ	s be executed sician and burial-transit		resulting in death) Last	Due to (or as	,	,						-		1	
68760,	w ~ w	lcai	1	d. Alcor	nolic	circh	0515							cn	ie year
<u> </u>	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:		,		**							_	
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pre					2	3d. Date of Month		y Day Year
•	that the de ed by the a detached f	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of de	eath 5L	Other (spe	спу)							,
	The law requires that the sie has been signed by th page 2 should be detache		Part II. Other significant condition	as contributing to death b	ut not rest	ulting in the u	nderlying car	use give	n in Part I.		23e. Did to	bacco us	se contribute	to the	cause of death?
rds	quires n sign ald be	d by	Acute renal.	failure							1 🗆 Y	es 2	7No 3□	Probal	bly 4 ∐Unknown
8	w require s been sign	jete						-			24a. Was a	an	24b. Were	autops	sy findings available
Vital Records,	The tav	ompleted									autop perfor	sy med?	prior t death	o comp	pletion of cause of
		0	25. Was case referred to medical						26. Place	of Death (1 ☐ Yes Check only o		1 L Y	es 2	L No
>	8 1	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatien	nt 3 DOA	Othe			5 ☐ Resid		□Other (S	pecify)	
	fter	Certification;	27. Manner of Death 1 ★Natural 5 Pending		y Year)	28b. Time of Injury	F 28	c. Injury Work	at	28	d. Describe h			,,,	
Division	at sat	fica	2 Accident investigation investigation and account of the country	ot be 290 Place of Ini	urv - At ho	me, farm, str			03 2	-	f. Location (S	treet and	Number or	Rurai I	Route Number.
ð	al or Attendi s after death. Il Director: A sd in by the fu	Serti	4 Homicide determin	building, et	c. (Specify	()					City or Tow				10010 775117507,
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	edicai (29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best examiner: On the basis of and manner sta	f examinat	wledge, death tion and/or in-	n occurred at vestigation, i	t the time	e, date and inion, deat	d place, and th occurred	d due to the o at the time, o	ause(s) a date and	and manner place, and d	as stat	ted. he cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier						number		1	29d. Date	signed (Mo	nth, Da	ay, Year)
)				Mo						00		Mar	دا د	20	05
	10		30. Name and address of person w	ho completed cause of d	leath (Item	23a) (Type,	Print)		1		- 1		erate e antelo	1777	21287
8	10		Dr. Jushua Tischell Schiffer ,	10 Jehns Ho	pkin 1	Hospital	Tower	110,1	Ductors	Loung	2,600 N	+hw	bife St, 6	Paltr	more, Maryland
	Sta		31. Date file MAPON, Pay Year)	the completed cause of d	ar's Signa	ture				-					
	Registr	ar		Proposition of	100	The Contract of the Contract o									

			1 - For State of Registrar		artment of Health and		/11115 15771
			Decedent's Name (First, Middle, Last)	- 00	Timeate of Death	2. Date of Death	g, No. 3. Time of Death
	Physici /Medic		Noah Brice Wal	ker		Month	Day Year 6:37 PM
)	Examin		4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or Location of Dea	th	4c. County of Death
		П	Sinci Huspital at	Billimore	Ballimore		N/A
	Funeral Director		5. Social Security Number 6. Sex 1217-48-7610	7. Age (In yrs. last birthday) 56 Yrs.) If Under 1 Year If Under 24 Hrs Months Days Hours Mir		9. Birthplace (State or Foreign Country) Maryland
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	neation		
	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Items 23e or 28e-f show event, I'm Medicul Examinar must be inclifted at	tor	Md. Baltimore	iod. Oxy, rown or E	Towson		10d. Inside City Limits 1 ☐ Yes 2 [X]No
	th the	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	ath wi		525 St. Francis Road		21286		USA
	er de:	Funeral	Armed Fo	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
936	72 hours after natural', or ite	by F	1 X Never Married 2 ☐ Married 1 X Yes If Yes, Gir 3 ☐ Widowed 4 ☐ Divorced Year or D	²□No /e ates:Vietnam	1 ☐ Yes 2 🗶 No Specify:		Specify: White
5-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupation a kind of work done during most of wo	orking 10	6b. Kind of Business/Industry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12) College (1	life.	DO NOT use retired)		C-3.C
	e filed within al Hygiene. other than '	e Co	17. Father's Name (First, Middle, Last)		Artist	me (First, Middle, Ma	Self Employed
Maryland	should be nd Mental marked c	ToB	Noah Lorian Walker.	٧		Katherine	
lary	2 shou and M is mar aumat		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street and Number or F	lural Route Number,	City or Town, State, Zip Code)
	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic	13	Mrs. Katherine W. O'Conno	r/Sister 130	9 Westellen Rd. T		
201	ages 1 nt of h : If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from		matory`or other place)		Oc. Location - City or Town, State
Baltimore,	permit. Pag Department Importent: Il any injury o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	,	alley Mem. Grd. 5		imonium, Maryland n Funeral Home, Inc.
Ba	permi Depa Impo any ii		> michael of Re				ryland 21204
			Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final	aused the death. Do not en ach line.	ter the mode of dying, such as cardia	c or respiratory arres	t, Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	(or as a consequence of):	ain Injury		16days
	Examiner			or as a consequence or).			
	pe tis	iner		of as a consequence of).			
	execution and al-tran	Examiner	that initiated events	(or as a consequence of):			X
8760,	death certificate be executed e attending physician and of for use as the buriat-transit		d				P CONTER
9	as as	Med	IF FEMALE:			100	TEO TATE
Вох	eath certif attending for use a	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, out		□Ectopic pregnancy	ORDIVED !	23d. Date of delivery Month Day Year
o.		Physician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregr 9 ☐ Unknown 9 ☐ Unkn		Other (specify)	Mecanion Approved V	
s, D	requires that the een signed by th hould be detache	by PI	Part II. Other significant conditions contributing to de	eath but not resulting in the u	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
ord	w requires that been signed I should be det					1 🗆 Yes	2 No 3 Probably 4 □Unknown
Vital Record	e law has b	ompieted				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of
a	i cian : Th certificate rector, pag	e Co	25. Was case referred to medical			1□ Yes 2	d? death? ¶No 1 ☐ Yes 2 ☐ No
	ys dii	To B	examiner?	npatient 2 ER/Outpatie	0.1	ath Check onl. one)	ce 6 □Other (Specify)
n of	i or Attending Ph after death. Director: After th in by the funeral		27. Manner of Death 28a. Date			28d. Describe how	
Division	Attending It death. sctor: After by the fune	icati	2万Accident investigation 3 ☐ Suicide 6 ☐ Could not be	of jury - At home, farm, st	M 1 ☐ Yes 2 No	Fan Fren	n Bicycle
<u>></u>	el or A s after I Direct	Certification:	4 Homicide buildi	ng, etc. (Specify)	reet, factory, office	Gity or Town	et and Number or Rural Route Number, State)
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Certifier 1X Certifying Physician: To the 2 Medical Examiner: On the b	best of my knowledge, deat	th occurred at the time, date and place	e, and due to the cau	se(s) and manner as stated. 2
	o the inthin 2 or the omplei	Med	29b. Signature and title of certifier	ner stated.	29c. License number	290	I. Date signed (Month, Day, Year)
	- > F 0		Dard Shuran		DIADIAFOG	W	hu 1 2505
	int		30. Name and address of person who completed cause	e of death (Item 23a) (Type,	Print)		1,200
	10.		Jucos Schwerz, m. D. Since	Besg: 59108	Mfmer, 2401 W. Sch	rolex Ave, le	31/6/more MD 21215
	Sta Registr		31. Date filed (Month, Day, Year) 32. R	aestrar's Signature	1		lay 1,2005
			0 2003	Calles In	EAGARS A		

DHMH 17 Rev 1/2001

Welker, Brice

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** TACK LEWIS 1420 WILLIBMS 4 М Agnic 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wiscossiv Autore MONTGOMERY 5480 CHELY CHURSE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F 279-28-8733 74 1930 Director Ohio Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits Show liem 27 is marked other then "naturat", or itams 23s or 28s-1 show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5480 Wisconsin Avenue Apt. 1530 20815 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 A No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within s 1 and 2 should be filed within if Health and Mental Hygiene Item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hays H. Williams Helen J. Books င္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an (Sister) Ann Keesey 3395 Dunmore Avenue NW Canton, OH 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1X Burial 2 Cremation 3 Removal from State Sunset Hills Memory 5-5-05 Canton, Ohio 4 ☐ Donation / 5 ☐ Other (Specify) 22. Name and Address of Facility Reed Funeral Home 21. Signature of Funeral Service Licensee 705 Raff Koad Sw Canton, OH 23a. Part I. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or high refailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARTBOLIGGERAGE CARDIBURSCULING DISEASE **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medicai the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe TOXOPUAS MESU 1 Yes 2 No 3 Probably 4 Munknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has autopsy performed?

1 Yes 2 XNo certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 XYes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After or Attending Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai completely (Check only one) within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Tho OWE) 015236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 Poce your Pike, Pockwille, 40 20857 WO CARL I MARGOLS 31. Date liled (Month, Day, Year) 32. Refistrar's Signature State 0 5 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State		State o	of Maryla		artment of I		-	-	0.00	
			Registrar 1. Decedent's Name (First, N	iddle. Las	at)			illicate of	Dealli	2. Date of De	Reg. No.	UUb	3 Time of Death:
П	Physici		Robert Lee		•	_				Month	Day	Year	12:40P M
	/Medio Examir		4a. Facility Name (If not instit					4b. City, Town, o	or Location of Dea	April		2005 County of Death	
	LAGIIII		Washington	Adve	ntist	Hospit	al	Takoma	Park		М	ontgome	rv
	Funeral		5. Social Security Number	6. Se	эх	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs		th v. Year)	9. Birth	place (State or Foreign
	Director		229-36-0823		MM 2□F		72 Yrs.	Worth S Days	710013		8,193		ginia
	and and		Usual Residence of Deceder 10a. State 10b. Co			10c.	City, Town or L	ocation					10d. Inside City Limits
	Mary f sho	ō	VA Pri	CO M	illiam	м	anassas						1 ☐ Yes 2 📉 No
	28e	Director	10e. Street and Number	ice w	TITIAIII	FI	allassas	10f, Zip Code			10g. Citiz	en of What Cou	intry?
	3a oi		7808 Oak St	reet				20111			U.S.		,
	deatl	Funeral	11. Marital Status		12. Was Dec			Was Decedent of I	Hispanic Origin? (Specify Yes or No		4. Race - Ameri	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any figury or other treumatic event. The Mystical Excitation must be notified at once.	by Fu	1 ☐ Never Married 2 💢 3 ☐ Widowed 4 ☐ Divo		1 XYes If Yes, Gi Year or D	2 No 19	49- 53	1 ☐ Yes 2 🔀 No		no rican, etc.)		Black, White Specify: Whi	
Ö	2 hor	ted	15. Dece	dent's Ed	lucation		16a. Dece	dent's Usual Occup	pation		16b. Kin	d of Business/I	ndustry
2	ithin 7	Completed	(Specify only his Elementary/Secondary (0-		College (life.	kind of work done DO NOT use retire	d) d)	orking			
2	ygien ygien yer th	Con	7					Carpente			1	structi	.on
and	be fill htal H ad oth even	Be	17. Father's Name (First, Mid							ame <i>(First, Middl</i> e Shiflett	, Maiden S	Sumame)	
Š	hould d Mer marke matic	٦	James William 19a. Informant's Name/Relai				10h Maili	ng Address (Street				T C4-4- 7	- 0.4.)
<u>N</u>	id 2 s Ith an 27 is a		Evelyn Doris			ife)		Oak Stre			-		•
<u>6</u>	Heal Heal Hem S		20a. Method of Disposition	WILLE	.mer (w		p. Place of Disp	sition (Name of	I	Date		ation - City or T	
Baltimore,	Page: ent of nt: If i		1 XBurial 2 □ Cremat 1 4 □ Donation 5 □ Othe				•	matory`or other pla lemorial	1	4/05	Foir	rfax, Vi	imainia
=	Departm Departm Importer any inju		21. Signature of Funeral Ser	-		1.6		2. Name and Addre		4/05			Street
m —	88 1 2 8		Juen	1.0	200	od I		Price Fu	neral Ho	me, Inc.	Mana	assas, \	7A 20110
		1	23a Part1. Inter the diseas shock, I heart failure.	List only	olications that one cause on e	caused the deach line.	eath. Do ne en	ter the mode of dyi	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
	Physician	"	Immediate Cause (Final disease or condition		m	40C	ardi	al 1.	nlar	ction			Onset and Death
	/Medical Examiner		resulting in death)		Due to	(fr as a cons	sequence of):	- WO 1	1	557-			12 - 8
		<u></u>	Sequentially list conditions,		b. Due to	(or as a cons) 891	084 6	1286	221-			1/2 hr.
Γ	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<		7	30400100 01).	*					
Ć.	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last		Due to	(or as a cons	sequence of):						
8760,	ite be nysicië he bu	dicai		l	d								-
39 2	entifica ling ph e as t	Med	IF FEMALE:										
Вох	attend for us	ian/	23b. Was decedent pregnan in the past 12 months?			birth 2 🗆 F	etal death 3[Ectopic pregnanc	у		2	3d. Date of deliv Month	rery Day Year
P.O.	w requires that the death certific been signed by the attending p should be detached for use as	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregi 9☐Unkn	nant at time o	of death 5	Other (specify)					,
٣.	that the ded by detail	y Ph	Part II. Other significant cor	ditions c	ontributing to d	leath but not)	resulting in the u	inderlying cause gi	ven in Part I.	23e. Did 1	obacco us	se contribute to	the cause of death?
rds	quires n sign ald be	Q P	Diale	i e	SA	rell	itu)		10	Yes 2	No 3□Pro	bably 4 Unknown
Ö		olete	HAYD	Wy	1-eus	jor	1 ,			24a. Was	an	24b. Were auto	opsy findings available
Re	The la	Completed								auto perfo	psy ormed? 2 2 No	prior to co death? 1 ☐ Yes	ompletion of cause of
Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certifit within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	BeC	25. Was case referred to me examiner?	dical					26. Place of De	eath (Check only o		1 165	20110
<u>></u>	Physic this ce al dire	To	1 Yes 2 No		Hospital: 1 🗆	Inpatient 2	ER/Outpatie	nt 3 DOA Ott	ner: 4 🗆 Nursing	Home 5 ☐ Resi	dence 6	□Other (Speci	fy)
Division of	ing P	on:	27. Manner of Death 1 Natural 5 □ Pe	nding	28a. Date (Mon	of Injury oth, Day Year	28b. Time of Injury	₩o	rk?	28d. Describe	how injury	occurred	
Sic	ttend death stor: /	icat	= L_ / 100100111	estigation uld not be		a of laine. A	A h a m a f a m a a]Yes 2□No	204 Leasting (Chanada		- 1 D- 1 - 1 - 1
2	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	4 Homicide de	termined	build	ling, etc. (Spi	at nome, rarm, st ecify)	reet, factory, office		City or To	wn, State)	Number or Hur	al Route Number,
_	spite	a C	29a. Certifier 15 Cert	ifying Ph	ysician: To the	e best of my	knowledge, dea	h occurred at the ti	me, date and plac	e, and due to the	cause(s) a	and manner as s	stated.
	ne Ho n 24 h	edical	(Check only 2 Med one)	ical Exam	niner: On the b	pasis of examiner stated.	ination and/or in	vestigation, in my	opinion, death occ	curred at the time,	date and	place, and due t	to the cause(s)
	To the To the Comp	ž	29b. Signature and title of ce	tifier		-1	^	29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
			> Kau	CLL	~ \(\)	($\sim 0.$	DI	1609		4.0	2905	>
	Q.		30. Name and address of pe	son who	completed cau	se of death	Item 23a) (Type		MAN	R. 1	ULI		-0.00
	0		31. Date filed (Month, Day,)	ear)		Registrar's Si	OIT!	F202	4 AITH	E125 B45	26-1	MD 20	08 18
	Sta Regist		MAY 0			iogiotial 5 SI	griature	02					
DHI	MH 17 Rev 1/2	-		201	11	With .	A A	24					
							ORIGIN	AL.					

			For State Registrar		State	of Maryla		artment of H		Mental H	ygiene ()5	15273
			1. Decedent's Name (i	First, Middle, I	ast)					2. Date of I	Death		3. Time of Death
	Physici		Charles			R.		Whitted	Sr.	April	$30^{\text{Day}}, 20$	Year	2:30A.M.M
	/Medic Examin		4a. Facility Name (If no	ot institution, o	ive street and n			4b. City, Town, or				nty of Death	2.001111
	L. Adiriii	C:	1270 Take	A				Pagad	one		Λn	ne Arı	undol
	Funeral		1378 Lake 5. Social Security Num		. Sex	7. Age (In yr	s. last birthday)	Pasad If Under 1 Year	If Under 24 Hr	s. 8. Date of E	Birth		place (State or Foreign
	Director		263-36-252	7	1 1 M 2 □ F	75	Yrs.	Months Days	Hours Mir		8.1929		ssouri
	ס		Usual Residence of De	ecedent						June	0,1727		
	nylan how		10a. State	0b. County		10c. 0	City, Town or Lo	ecation				1	10d. Inside City Limits
	e-fs	Director	Maryland	Anne A	Arundel	Pa	asadena						1 □ Yes 2 ☑ No
	or 28	ire	10e. Street and Number	er				10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	th wi		1378 Lake	Ave.				211	22			II S /	4
	dea dea	Funeral	11. Marital Status		12. Was De Armed F	cedent Ever in Forces?		Was Decedent of H	spanic Origin? (Specify Yes or I		ace - Americ	
ထ္	or it	F	1 Never Married	177		2 □ No 10	9/19_	1 ☐ Yes 2 ☐ No	Specify:	,	Spec		0.00
ဗ္ဗ	irel',	d by	3 Widowed 4		Year or	Dates: 10	953					Wł	nite
<u>ν</u>	72 h	Completed		Decedent's only highest g	Education grade completed	d)	(Give	dent's Usual Occupa kind of work done	furing most of w	orking	16b. Kind of	Business/In	dustry
2	Mithin Dan Dan	mp	Elementary/Second	ary (0-12)	_	(1-4or 5+)		DO NOT use retired					
2	iled v tygie ther t		17. Father's Name (Fin	ret Middle I a	2		Flec	trical En		ame (First Midn	Univer		of Maryland
ă	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "neturel", or items 23e or 28e-f show imatic event, it a Modical Examirer must be notified at	Be			31)		T 75					,	
څ	should Ind Men	To	Raymond 19a. Informant's Nam		(Time Brint)	F		itted ng Address (Street a	Dorotl		G.		Rogers
Maryland 21215-0036													C009)
	of Health item 27 I		Nellie L. 20a. Method of Dispos		ed (Wife		Place of Dispo	B Lake Av	e.Pasado	ena, Mar Daté	yland 2	1122	own State
ַסַ	Pages nent of I int: If it		1 Burial 2 0	Cremation 3		n State	cemetery, crei	matory or other plac	. 1		EGG. EGGGNIO	. Only of to	mi, otalo
altimore,	t. Partmer		°4 □Donation 5			Cı		lle V.A.		3 / 05	Crown	sville	e, Maryland
Ba	permit. Pages Department of Importent: If it any Injury or c		21. Signature of Fune	rar Service Lic	ensee	//	1 1	Name and Address	olvniak	Funeral	Home,	P.A.	
	402 60		1	Tu &	M			<u>3204 Moun</u>	tain Koa	ad Pasad	ena, Ma	ryland	Approximate
			23a. Part1. Enter the shock, or heart f		ly one cause on	each line.	am. Do not en	er the mode or dyin	y, such as cardi	ac or respiratory	arrest,		Interval Between Onset and Death
	Physician		Immediate Cause (Fir disease or condition resulting in death)	nal	_ aPa	ncreati	ic Cance	er					
	/Medical Examiner		resulting in death)		Due to	o (or as a cons	equence of):						
		_	Sequentially list condi	itions.	b. — Duo t	o (or as a conse	aguanaa af):						
T	ped lisit	Examiner	Sequentially list condi if any, leading to immi cause. Enter Underly Cause (Disease or inj	ing	Due	o (oi as a consi	equence or).						
V _	and I-tran	хап	that initiated events resulting in death) Las		c	o (or as a cons	equence of):						
8760,	ficate be executed physician and s the burial-transit	alE					-,-						
	cate phys	dical			d								
9 ×	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE:		23c. If yes. o	utcome of preg	inancy				034 [Data of dollar	
P.O. Box	atten for u	ian	23b. Was decedent pr in the past 12 mg	onths?	1 Live	birth 2 ☐ Fe	etal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	Day Year
o	he de	ysic	1 □ Yes 2 ☑1 9 □ Unknown	No	9□ Unk		death 3L	3 Other (specify)					
_	that the de led by the a detached (H.	Part II. Other significa	ant condition:	s contributing to	death but not re	esulting in the u	nderiving cause give	en in Part I.	23e. Dio	I tobacco use co	ontribute to th	ne cause of death?
ds,	uires tha signed d be del	d by		iomyopa						10	Yes 2 No	3 Prob	ably 4 Unknown
Division of Vital Records,	w requir been si should	Completed	- Odia.	Lomyope	LLILY	,				240 146	24	. 14/2-2- 2-42	findings available
ĕ	e law has je 2 s	mpi								24a. Wa	opsy formed?	prior to cor death?	psy findings available mpletion of cause of
=										1 ☐ Yes		1 Yes	2 AHO
ij	ysiclen: Th is certificate director, pag	Be	25. Was case referred examiner?		Hospital:			other all DOA Other	200	eath (Check only			
5	Phys this al dir	2	1 Yes 2 No	0	11		ER/Outpatier	IL 3D DOA	4 🗀 Nul Sing		sidence 6 0		r)
Ĕ	Attending Physiclen: ir death. ector; After this certifica	ion	27. Manner of Death 1 ☑ Natural	5 Pending	(Mo	e of Injury onth, Day Year)	28b. Time o Injury	Worl		280. Describ	e how injury occ	·	
<u>S</u>	tend death tor:	cat	2 ☐ Accident 3 ☐ Suicide	investigat	he	an of laines. At	hama form at		Yes 2 □No	29f Legation	(Ctront and Nur	mbor or Pum	al Route Number,
\leq	for Attendation of the death Director:	Certification;	4 - Homicide	determin	ed 286. Plai	ding, etc. (Spe	city)	eet, factory, office			оwп, State)	noer or nura	, noute Number,
_	Hospitel		29a, Certifier 1	Cortifuina	Dhysician: To d	he heat of my k	newladge deat	h occurred at the tim	o data and alac	and due to th	0.0000000000000000000000000000000000000		Pated
	Hos 24 hc Fun Fun	Medical	(Check only 2[☐ Medicel Ex	eminer: On the	basis of exami	nation and/or in	vestigation, in my of	pinion, death occ	curred at the time	e, date and place	and due to	the cause(s)
	To the Hospitet or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Mec	29b. Signature and titl	le of certifier	210 1116			29c. License	number		29d. Date sign	ned (Month,	Day, Year)
	F 3 F 8			1	/			DOG					
	/		30. Name and address		o completed as	usa of direct h	om 22a) /Tun-		3557		May 5	5, 200.	5
	511				M D				1 5			<u> </u>	1401
	Sta	te	Anthony 31. Date filed (Maria)	y Caput (Pay Year)	32	Aegistrar's Sig	nature U DOLOII	ons Islar	id Koad	Annapol:	is Maryl	and 2	1401
	Registi		THI A()	052	005	Marco	nature	- 10					
					. 4		- Co.						

			1 - For Stata Registrar		laryland / De _l		Health ar	•	giene 5	15274
			1. Decedent's Name (First, Middle	, Last)				2. Date of D Month	eath	3. Time of Death
	Physici /Medi		CALVIN B. WE	EMS				APRIL	Day Year	3 10 10 14
	Examir		4a. Facility Name (If not institution			4b. City, Town,			4c. County of D	eath
			SINAI HOSP				IMORE		N/A	
	Funeral Director		5. Social Security Number	6. Sex 7. A 1 ☐ XM 2 ☐ F	ge (In yrs. last birthda	y) If Under 1 Year Months Days		Min. (Month, D	ay, Year)	Birthplace (State or Foreign Country)
			217-18-6407 Usual Residence of Decedent		82 Yrs.			3-11-1	923 MA	RYLAND
	nyland how		10a. State 10b. County		10c. City, Town or			production to the same of the		10d. Inside City Limits
	Ba-f s	cto	MD. N/A		BALTIM	ORE				1 XYes 2 No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	s 238	rai	1622 McKEAN	AVE .	Suria II S		217	0./0	USA	
10	ter de	Ľ,	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Forces	?	If Yes, specify Cub	oan, Mexican, P	n? (Specify Yes or N Puerto Rican, etc.)	Black, W	merican Indian, hite, etc.
980	urs al	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	1 ☐ Yes 2 XNo	Specify:		Specify: B	LACK
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show to Medical Exp. iner: wat be notified at	Completed by Funeral	15. Decedent (Specify only highes	's Education	16a. Dec	cedent's Usual Occur	pation during most of	f working	16b. Kind of Busine	ss/Industry
21	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	ve kind of work done . DO NOT use retire		, monthly		
7	filed w Hygie other t		-12- 17. Father's Name (First, Middle, I	-0-	TR	UCK DRIVE	_	s Name (First, Middle	GOVERN	MENT
and	ould be f Mental H varked of	o Be	MALCOLM WEEMS	-				CHEL HEBRO		
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, I.e. Ms	2	19a. Informant's Name/Relationsh		19b. Ma	iling Address (Street			er, City or Town, State	a Zin Code)
	1 and 2 Health a tem 27 is		FLORETTA WEER	MS(WIFE)					MARYLAND 2	
Baltimore,	perrilt. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23e or 28e-1 show any injury or other traumatic event, Ital Medical Eras in art is at Le rodified at 2006.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	0.55	20b. Place of Dis	position (Name of rematory or other pla	ice)	Date	20c. Location - City	or Town, State
Ē	Page ment ant: if ury o		'4 □ Donation 5 □ Other (St	ecify)	, ,	MEMORIAL :	,	-6-2005	BALTIMORE	, MARYLAND
3alt	perrit. Pages Department of H Important: if ite any injury or of		21. Signature of Fyne I Service I	idense JONATHAI	100				FUNERAL HO	•
=	₫ O E @ O		jarat	~ U. Ac						RYLAND 21217
			23a. Part 1. En in the disease, or shock, or heart failure. List	only one cause on each	line.	inter the mode of dyi	ng, such as ca	irdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate (Luse (Final disease or or dition resulting in death)	seps						2 days
	Examiner			0.50	s a consequence of):					2 days
		Je.	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	D	a consequence or);					
V	cuted	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G.						
Ő,	siclan and burial-transit		resulting in death) Last	Due to (or a	s a consequence of):					
68760,	w - w	dical		d						
9 X	death certificat attending phy I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregnancy				001.0	
Вох	atten atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal death 3	☐Ectopic pregnanc	у		23d. Date of o Month	Day Year
0	t the de by the tached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
о, С	The law requires that the ste has been signed by th page 2 should be detache	by P	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
rd	v require been sig should b							_ 10	Yes 2 □ No 3 □	Probably 4 Unknown
Records,	e law r has be je 2 sh	Completed						24a. Was		autopsy findings available completion of cause of
E H	The I	Con						perfe 1 ☐ Yes	ormed? death	?
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		L O#		Death Check on		
o		. To	1 Yes 2 No 27. Manner of Death	1 Linpat	ient 2 ER/Outpati ury 28b. Time	ent 3 DOA "	v at		dence 6 Other (S)	pecify)
on	iding F th. : After s funera	tlor	1 Natural 5 Pending 2 Accident investig		ay Year) Injury	Wo	rk? Yes 2 □ No		now injury occurred	
Division	of or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could n	ot be 28e. Place of Ir	jury - At home, farm,	street, factory, office		28f. Location (Street and Number or	Rural Route Number,
Ö	7 2 2	Certification;	4 E Monneide	bullding, e	tc. (Specify)			City or To	wn, State)	
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in 1		(Check only 2 Medical 8	Physician: To the bes	of my knowledge, de	ath occurred at the tr	me, date and p	place, and due to the	cause(s) and manner	as stated.
	the Ithin 2. the Ithin 2. the Ithin 2. mplet	Medical	one) 29b. Signature and title of certifier	and manner s	tated.	29c. Licens				
	5 × 6 × 6		and the or certifier	<u>u</u>				00	29d. Date signed (Mo	
7	/		30. Name and address of person v	who completed cause of	death (Item 23a) /Tim	a Print)	-> - 0		HIK 3	0,005
	5		RANJANI R	AMAMATITY	m MD	SIN	AFL It	OSPITAL	OF BATT	0,2005 MORE
	Sta		31. Date filed (Month, Day, Year)		rar's Signature	1				
	Registi	ar	MAY 0	2005	sur St.	A SHALL				

			1 - For State Registrar	State	of Maryla			of Health a of Death	ind Menta		ene . n2		1 []]
		п	Decedent's Name (First, Middle	e, Last)						of Death			3. Time of Death
	Physici /Medio		CHARLOTTE A	NNE WILLI	AMS				MAY	1, 2	2005	'ear	8:30 P ^M
	Examir		4a. Facility Name (If not institution	_				wn, or Location of			4c. County of		
			8218 DIAMON 5. Social Security Number	D POINT RO		s. last birthday)	E/	ASTPOINT Year If Under 2	A Mes	15111		LTIM	
	Funeral Director		220-30-2691	1□M 2□F	7. Age (117)			Days Hours	Min. (Mor	of Birth oth, Day, Y 24,	ear) 9	Count	ace (State or Foreign try) MD.
	pu ,		Usual Residence of Decedent							24,	1754		
	faryla f shov	ō	,		100.0	City, Town or Lo						10	od. Inside City Limits 1 ✓ Yes 2 □ No
	28a-	Director	MD . N/	A	L	BALT	10f. Zip Ci	ode		100	. Citizen of Wha	at Count	
	th with		3107 O'DONN	ELL STREE	T			21224		_	NITED ST		,
	tems tems	Funerai	11. Marital Status	Armed F	edent Ever in orces?	U.S. 13.	Was Deceder	t of Hispanic Orig Cuban, Mexican,	in? (Specify Yes Puerto Rican, e	or No-	14. Race -	America White, e	
30	hours after death with the Maryland tural', or liems 23a or 28a-1 show al Examinar must be notified at	by Fi	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes G	ive A		1 ☐ Yes 25			,	Specify:		ITE
2-003p	"natural",	ted	15. Deceder	nt's Education		16a. Deced	dent's Usual (Occupation		16	b. Kind of Busin		
Z	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	st grade completed) College (life. I	DO NOT use	•	of working				,
7	iled w lygier ther th		5TH 17. Father's Name (First, Middle,	Lact)			HOMEMA				OWN HO	OME	
aua	ld be f ental } ked of	o Be	WALTER LANGLE	•					's Name <i>(First, 1</i> RLOTTE S	•			
ary	d 2 should th and Mer ?7 is marke traumatic	1	19a. Informant's Name/Relations			19b. Mailir	ng Address (S	treet and Number				ate, Zip (Code)
, Na			SHERRY JACKSO	N/DAUGHTE	R								LAND 21224
ore	permit. Pages 1 and Deprument of Healt Important: If item 2 any njury or other once.		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation	3 Removal from	_	Place of Dispo cemetery, cren LTIMORI	natory or other	r olace)	Date	20	c. Location - Cit	ty or Tov	vn, State
	it. Pa irtmen irtant: njury		' 4 ☐ Donation '5 ☐ Other (S	Specify)	DA	CREMAT	TORY	; =	5/6/05		UREL, M		
ğ	Depression of the sany in sany		Le a les	The firm)			Address of Facility					
7			23a. Part1. Ent the disease, or shock, or that failure. List	complications that	caused the dea								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	5	n 0/1	100	// /	UNG	CAN	M.P.	R.	. 9	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):	, /	16	1. 1 :		2 1	7	
		į.	Sequentially list conditions, if any, leading to immediate	b. Wr	(or as a conse	Mer	4ST	436 1	0/10	er,	5/4110	Ko.	ne ye
/	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	\$	(0, 20 2 00.150	14401100 01).							/
ĵ	e exectant and and arrial-tr		resulting in death) Last	Due to	(or as a conse	equence of):							
2/00	icate be executed physician and s the burial-transit	dicai		d									
o XO	.≘ On or	0	IF FEMALE:	23c. If yes. or	tcome of pregr	nancy							
00	death e atten ed for u	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live I	birth 2 Fei	tal death 3	Ectopic pregi				23d. Date of Month		y Day Year
S	it the c by the tacher	hysi	9 🗆 Unknown	9□ Unkn									
ń	w requires that the death cer been signed by the attendin should be detached for use	by P	Part II. Other significant condition	ons contributing to d	leath but not re	sulting in the ur	nderlying caus	e given in Part I.	23e	Did tobac	co use contribu	te to the	cause of death?
coras	requii	eted							-	1 🗆 Yes	2 No 3] Proba	bly 4. Dunknown
Ž)	e la has je 2	Comple	 						24a.	Was an autopsy performed	prior	r to com	sy findings available pletion of cause of
VII		e Co	25. Was case referred to medica					00.00		Yes 2		Yes 2	?□ No
		To B	examiner? 1 ☐ Yes 2. 2. No	Hospital:	Inpatient 2[☐ ER/Outpatien	t 3 DOA	044	of Death (Check sing Home 5		e 6 MOther /	Specify)	DAUGHERS
	ding Phys n. After this funerat di		27. Manner of Death 1. Natural 5 Pendin	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury		Injury at Work?			injury occurred	Эргонуу	Here
<u> </u>	Attending or death. ector: After by the fune	cati	2 Accident investig	gation oot be		1	М	1 ☐ Yes 2 ☐ No					
2	after of Direction by	ertification:	4 Homicide determ	ined 286. Place	e of Injury - At I ing, etc. (Spec	home, farm, stre lify)	eet, factory, o	fice	28f. Loca City	tion (Stree or Town, S	t and Number o tate)	or Rural	Route Number,
	ospita hours ineral y fillec	O	29a. Certifier 1 Certifyin	ng Physician: To the	e best of my kn	lowledge, death	occurred at t	he time, date and	place, and due t	o the caus	e(s) and manne	er as sta	ted.
	To the Hospital or Attend within 24 hours after death To tha Funeral Director: completely filled in by the	ledical	one)	and man	asis of examin	ation and/or inv	estigation, in	my opinion, death	occurred at the	time, date	and place, and	due to t	he cause(s)
	To t To t	Σ	29b. Signature and title of certifie) Ko	:00	11		cense number			Date signed (M		ay, Year)
	10		20 Nome and address of	- / (M		4749		MA.	AY 2, 20)05	
	V		30. Name and address of person ALLEN REILLY,					CK, MD. 2	21701				
	Sta		31. Date filed (Month, Day, Year)	3	Registrar's Sign		4.				-		
	Registr	ar	MAY 0.5 3	2095 ASS	WALL A	1000							

			1 - For AMEND#8 4/19/0 Registrar AACO HFALTH	State of N	Marylan	•	artmen rtificate			and M	•	giene	005	15276
			1. Decedent's Name (First, Middle, L								2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Alice B. Aver	sa							Apr.	8,	2005	11:00a M
	Examin		4a. Facility Name (If not institution, g.		er)		4b. City,		Location of			4c. C	ounty of Dea	
4			Genesis Elder 5. Social Security Number 6.		Age (In yrs. i	(ant historia)	If I Inder	Seve 1 Year	rna I		8. Date of Bir	No.		Arundel
	Funeral Director		218-03-4922	1 M 2 S F	84	Yrs.	Months	Days	Hours	Min.	/Month, Da	y, Year)	42 9. BI	thplace (State or Foreign ountry) MD
			Usual Residence of Decedent								Aug. 16.		72	
	nylan how		10a. State 10b. County	Amundo I	10c. City	y, Town or Lo		_			,			10d. Inside City Limits
	e Ma Sa-f s	cto	MD Anne	Arundel				Arno	ΣŢď					1 ☐ Yes 2 ☑ No
	vith th	Dire	10e. Street and Number	1 5 7			10f. Zip	Code	04.044			10g. Citize	n of What C	ountry?
	deeth with the Maryland rms 23a or 28a-f show r rust be notified at	Funeral Director	779 Dividing Cr	eek Road	at Ever in II	6 10 1	Man Dagge	tont of U:	21013		aife. Van ar Na	14	USA	erican Indian,
	item iner	nn-	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Force	s?	3.	f Yes, spec	offy Cuba	n, Mexican	, Puerto F	cify Yes or No Rican, etc.)		Black, Whi	te, etc.
5	hours after tural, or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	_		1 ☐ Yes	2 X No	Specify:			S	pecify:	White
215-0036	n 72 hours after deeth with the Marylar "natural", or Items 23a or 28a-f show patical Examiner must be notilised at	Completed	15. Decedent's (Specify only highest of	Education		16a. Deced	dent's Usua kind of wo	al Occupa	ation	t of workin	ıa	16b. Kind	of Business	/Industry
7	d within 72 giene. ir than "nai	npie	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. I	ilk S	se retired,)			Mo	stingh	OUGO
N	77 75 10		8	-41		5	TIV D	CICC						
פעב	be dala	Be	17. Father's Name (First, Middle, Last John T. Johns								(First, Middle, L. Ro		Imame)	
Maryland	should Ind Men	٦ ا	19a. Informant's Name/Relationship			19b Mailir	na Address	(Street a			Route Number		own State	Zin Code)
<u> </u>	S 6 7 6		Vince Aversa,		and		•				d, Arno			012
ē,	s 1 and of Health item 27 other to		20a. Method of Disposition		20b. P	lace of Dispo emetery, cren	sition (Nan	ne of		D	ate			Town, State
Ē	Pages tment of tant: If it jury or o		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec			adowri				Apr	2005	Elk	ridge	, MID
Baitimore,	orts orts inju		21. Signature of Funeral Service Lic	ensee	0	22	Name an	d Addres	s of Facilit			erna	Park 1	Funeral Home
n —	Den Pen Pen Pen Pen Pen Pen Pen Pen Pen P		U/M2	1	le	4	495 G	OV. 1	Ritch	ie H	v. Set	rerna	Park,	MD 21146
			23a. P. c. Enter Passe, or co shock, or ailure. List on				er the mod	e of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		fimediate Cause (Final disease or condition resulting in death)	_ a	10V T									Onset and Beatin
п	/Medical Examiner		resulting in dealing		as a consequ		2.0	CA	1 ilie	-10	SCULA	1 77	1000	5
		er	Sequentially list conditions, if any, leading to immediate		as a consequ		0/10	91	rCD((J V ()	3000	-	12612	C
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
o`	be executed sicien and burial-transit		resulting in death) Last	Due to (or a	as a consequ	uence of):								
3760,	# > e	licai	•	d										
X 68	ertifica ling ph e as th	Physician/Med	IF FEMALE:	20- 11										-
Rox	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant	2 🗆 Fetal	Idéath 3□	Ectopic pr					230	d. Date of de Month	livery Day Year
o.		ysic	1 □ Yes 2 🖾 No 9 □ Unknown	9□ Unknown		eath 5	Other (sp	ecily)						
1	The law requires that the tee has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions	contributing to death	n but not resi	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco usa	contribute t	o the cause of death?
rds	w requires been sign should be		Ш								1 🗆 `	res 2 🗆	No 3□P	robably 4 Dunknown
ecords,	aw re	plet									24a. Was			utopsy findings available completion of cause of
I.	The law cate has page 2 a	Completed										rmed?	death?	
Vital	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
010	Physician: r this certific ral director.	မ	1 ☐ Yes 2 No	Hospital: 1 □ Inpa		ER/Outpatien			4 A INU		e 5 Resid			ecify)
	fte ane	ion:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Ir (Month, I	Day Year)	28b. Time of Injury	M Z	8c. Injury Work	rat ⟨? Yes 2. □I		8d. Describe I	now injury o	occurred	
Division	Attending is death. ctor: After by the fune	fical	2 Accident investigat 3 Suicide 6 Could not	be 28e. Place of	Injury - At ho	ome, farm, str			, , , ,	-	8f. Location (Street and f	Number or R	ural Route Number,
2	after after Dire	Certification:	4 Homicide	building,	etc. (Specify	()					City or Tox	vn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying I	Physician: To the be eminer: On the basis	est of my kno s of examina	wledge, death	h occurred vestigation	at the tim	ne, date an	d place, a th occurre	nd due to the d at the time,	cause(s) ar	nd manner as	s stated. e to the cause(s)
	thin 2 the I the I mplet	Medical	one) 29b. Signature and Illia Certifler	and manner					number					th, Day, Year)
	With		SIM	and	Ma)	0	217	776	>		APRU	8,	2005
			30. Name and address of person wh	o completed cause of	of death (Item	1 23a) (Type.	Print)					11	1 1	2005
			SURLEM MUI	Y DRA	300	15-	HAN	DVE	R S-	7	ACIM	CORE	. 2((()
	Sta Registr		31. Date filed (Month, Day, Year) 2	2005	strar's Signa	ture	hook	9						

				/ Department of Health and M		3	12077
	• • • • • • • • • • • • • • • • • • • •		1 - State Registrar	Certificate of Death	Re 2. Date of Death	g. No. UUJ	10211
	Physici	an	1. Decedent's Name (First, Middle, Last) Dallas G.	Plair	Month	Day Year 19 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Abiti	4c. County of Death	9:24p M
	_xam.		Shady Grove Adventist Hospital	Rockville		Montgon	nerv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth;	place (State or Foreign
	Director		214-16-1959 80 Usual Residence of Decedent	115.	Dec. 30,	1924 Mai	ryland
	nyland how		10a. State 10b. County 10c. City,	Town or Location			10d. Inside City Limits
	Ba-f s	Director	Maryland Montgomery Boyd	S			1 ☐ Yes 2t No
	with the		10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coul	ntry?
	ne 23	Funeral	22400 Clarksburg Road 11. Marital Status 12. Was Decedent Ever in U.S.	20841 13. Was Decedent of Hispanic Origin? (Spe		United Stat	
9	or iter	Fu	Armed Forces? 1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 2 🖾 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
003	within 72 hours after death with the Maryland ene. than "neturel", or Iteme 23a or 28a-f show the Marical Examiner must be motified at	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Wh	ite
<u>-</u>	n 72 t	Completed	(Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workillife. DO NOT use retired)	ing 1	6b. Kind of Business/In	dustry
212	d withi	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Owner/Operator		Auto Body S	Shop
힏	should be filed within 72 hours after death with the Marylar vid Mental Hygiens. Transked other than "neturel", or fleme 23a or 28a-f show marked other than "neturel", or fleme caust be notified at matte event, the Macalcal Examiner must be notified.	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name			
Maryland 21215-0036	ould b Ments arked	P.	George B. Blair	Laura He	len Drur	у	
Mar	d 2 sh h end 7 is m treum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura			
ر ف	1 and Healt tem 2			22400 Clarksburg Road, ce of Disposition (Name of netery, crematory or other place)		Maryland 20 Oc. Location - City or To	
ē	Pages ent of nt: if if		1 E3 Buriat 2 Cremation 3 Hemoval nom State	ksburg, U. M. Cemetery	2005	Clarksburg,	
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health end Menta importent; if item 27 is marked any injury or other treumatic es once.		21. Signature of Euneral Service Licensee	22. Name and Address of Facility Olin L. Molesworth 1	D A E	norel Home	Maryland
m	88 5 8	1/2	Jode Ollyn	26401 Ridge koad, Da	amascus,	Maryland 2	.0872
1			23a. Part. Enter the disease, or complications to t caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac o	r respiratory arres	st,	Approximate Interval 8etween Onset and Death
- 13	Physician /Medical			endin hyfordin			· The
	Examiner		Due to (or as a conseque	nce of):			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):			
	nd transit	Examiner	that initiated events c.				
760,	ate be executed hysician and the burial-transit	i Ex	resulting in death) Last Due to (or as a conseque	nce of):			
687	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai	d				
ŏ	eath certific attending p for use as (Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant			23d. Date of delive	ery
m	death le atte	sicia	in the past 12 months? 1 Yes 2 10			Month	Day Year
о. О	at the ded by the setached	Phys	9 🗆 Unknown		00 8:444		
က်	ires that signed b	ρλ	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.		acco use contribute to that a 2 □ No 3 □ Prob	
ecords,	w require been si should I	Completed		······	24a. Was an		psy findings available
ě	0 5 0	dmo			autopsy perform	ed? prior to condeath?	mpletion of cause of
Vital	sician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death		No 1 Yes	21110
01 <	Physical this ce al direc	To B		Outpatient 3 DOA Cther: 4 Nursing Hor	ne 5 ☐ Resider	nce 6 Other (Specify	<i>(</i>)
S C	ding P h. After t funera		1 Natural 5 Pending (Month, Day Year)	8b. Time of 28c. Injury at 2 Work?	28d. Describe how		
Division	or Attendi ter death. irector: A n by the fu	licat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hom	M 1 Yes 2 No	28f. Location (Stre	et and Number or Rura	I Route Number
2	al or At atter i Direc d in by	Certification:	4 Homicide determined 288, Place of Injury - At nom building, etc. (Specify)	o, rami, otrosi, rasiory, omos	City or Town,	State)	7 10210 74111001,
	To the Hospital or Attending Physician: within 24 hours atter death and To the Funeral Directors After this certific completely filled in by the funeral director,		29a. Certifier (Check only (Ch	edge, death occurred at the time, date and place, a	and due to the cau	use(s) and manner as st	ated.
	To the H within 24 To the F complete	Medicai	one) and manner stated.				
	or with	_	29b. Signature and title of contifier	29c. License number Do754755	. 290	d. Date signed (Month,)	Day, Year)
	6		30. Name and address of person who completed cause of death (Item 2			ye. I	1000
	\cup		Sunil Saxena MD 9901 Medical Cen		Marvland	20850	
	Sta		31. Date filed (Month, Day, Year) 32. Resistrar's Signatur	Э		20030	
	Registr	ar	APR 2 2 2005	& And			

			1- For State of Maryland	-	rtment e			nd Me		jiene	105	15278
	Physicia	an	1. Decedent's Name (First, Middle, Last) Robert James Beavers						. Date of Dea Month	th Day	Year	3. Time of Death
ز	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	own, or l	Location of		pril_	4 c . Cou	2005 nty of Deatl	
			Spa Creek Center Genesis Elder		Ann						Arun	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) _ Yrs.	If Under 1 Months [Year Days	Hours 1	Min.	. Date of Birtl (Month, Day	, Yeer)		hplace (State or Foreign untry)
	D		Usual Residence of Decedent					P	pril 8	1920) Per	nnsylvania
	larylar show	j.	Maryland Anne Arundel Annap	Town or Loc	ation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28e-1	rect	10e. Street and Number	70118	10f. Zip C	ode				10g. Citizen	of What Co	untry?
	th with	al D	103 Lee Drive		21	403				Unite	i Stai	tes
	ified within 72 hours after death with the Maryland typiene. other then "naturel", or items 23e or 28e-1 show ont, tra McJicul Ezan, er must be notified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 N	13. W	Vas Deceder Yes, specify	nt of His y Cuban	panic Orig , Mexican,	jin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14. F	Race - Ame Black, White	rican Indian, 9, etc.
0000	ours af	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	☐ Yes 2	X ^{No}	Specify:			Spe	cify: wl	hite
ה ה	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual (kind of work	done di	urina most	of working		16b. Kind of	Business/l	Industry
7	within iene. then	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	machi		reureu)				too1	compa	any
D	be filed within 72 hours after death with the Marylan half lygiene. Id other then "naturel", or liems 23e or 28e-f show other transfer recitified at event, It a Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)						First, Middle,		ame)	
yland	2 should be and Mental ris marked or reumatic ever	To	Jacob Beavers	405 14-18-	- 4 //	01					Ct. to 3	To Codel
Mar	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Linda Serpico / daughter						Route Numbe	•	vn, State, Z	up Code)
je,	of Health of Health if item 27 or other tr		20a. Method of Disposition 20b. Plac	e of Dispos	sition (Name	of	1	Da		20c. Locatio	n - City or	Town, State
Баппо	Pages ment of tent: If it				ad Me							lorida
Dan	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee									al Home, Inc , MD 21401
			23a. Part1. Enter the disease, or complications that caused the death.								JULIE	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	1 Mc	NIA	_						Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequent		10-7-1							
L		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	nce of):	-							
	cuted nd ransit	Examiner	that initiated events c.									
3/60,	certificate be executed rding physician and ise as the burial-transit	cal Ex	resulting in death) Last Due to (or as a consequen	nce of):								
280	ficate physics the	ᇹ	d									
XOD	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal de		Ectopic preg	anancy					Date of deli	,
	ne death the atter hed for u	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No 9 □ Unknown		Other (spec						Month	Day Year
ŗ	that fhe de led by the a detached f		Part II. Other significant conditions contributing to death but not resulting	ng in the un	nderlying cau	ise give	n in Part I.		23e. Did to	bacco use c	ontribute to	the cause of death?
cords	w requires that s been signed to should be deta	ed by	RECURENT Clostaioium D	15-Fic	ile (Coli	tis		100	es 2 🗆 No	3 □ Pr	obably 4 □Unknown
eco	law re	Completed							24a. Was autop	sy	prior to d	topsy findings available completion of cause of
z a	ician: The law certificate has rector, page 2 !								1 Yes	2 No	death? 1 ☐ Yes	2□ No
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EF	R/Outpatient	1 3□ DOA	Othe	- 1 -		Check only o		Other (Spec	cify)
n O		on: T	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 28	8b. Time of Injury		c. Injury Work	?		d. Describe h	ow injury occ	curred	
DIVISION	Attending or death. ector: After by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be	e farm stre	M and factory		es 2□N		If Location (S	treet and Nu	mber or Ru	ıral Route Number,
2	after I Direct	ertif	4 Homicide determined building, etc. (Specify)	0, 14111, 0110	Joi, 140,017, 1	011100			City or Tow			
	To the Hospitel or Attentwithin 24 hours after dealt To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at restigation, in	the tim	e, date and inion, deat	d place, an	d due to the d at the time, d	ause(s) and date and place	manner as	stated. to the cause(s)
	To th To th сощр	₩ (29b. Signature and title of certifier	115	29c. I	License	number	7:6		29d. Date sig	ned (Month	h, Day, Year)
			M		/	ン	> 2	24	7	HPR:	, 2	
			30. Name and address of person who completed cause of death (Item 2:	3a) (Type, F	Print) DSA	ENC	& H	19/11	w. C.	440	A	RYLMS 21401 NAPOLIS
•.	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	TB 4	1 4		-1	1,000	7 30.	. 1-0	. 110	7
b	Regist	rar	APR 11 200	A A	934							

		1 - For State Registrar	State of Maryland	-	artment of Hortificate of L		nd Men		ene	05	15279
Physic		1. Decedent's Name (First, Middle, Last) Vyolet J. Churc	h				N.	eate of Death Month	Day	Year 005	3. Time of Death 8:24 a ^M
/Medi Exami		4a. Fecility Name (If not institution, give s 6428 Cherrywalk	treet and number)		4b. City, Town, or Quant	ico	Death	PIII 2	4c. Coun	ty of Death	
Funeral Director		5. Social Security Number 6. Sex 227-24-2347	7. Age (In yrs. last) 78	Yrs.	If Under 1 Year Months Days	Hours	Min. 8. D	ate of Birth Month, Day, /24/19	(ear) 926	9. Birthp Cour	olece (State or Foreign olay) VA.
death with the Maryland ms 23a or 28a-f show must be multied at	Director	10a. State 10b. County MD Wicomic	10c. City, T	own or Lo Quant				10	g. Citizen of		10d. Inside City Limits 1 Yes 2 No
ath with	rai Dir	6428 Cherrywalk R			2185					USA	
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates:	1	Was Decedent of His f Yes, specify Cubar I ☐ Yes 28 No	spanic Origin, Mexican, I	n? (Specify ` Puerto Ricar	Yes or No- n, etc.)	Bla	ice - Americ ack, White, ify: Whi	etc.
filed within 72 hours after Hygiene. other than "natural", or ite	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 1 completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired;	urina most c	of working	1	6b. Kind of I		dustry
ould be filed within Mental Hygiene. serked other then satic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) John Levin Mears		Г	armer			der Me	aiden Surna	ain me)	
s 1 and 2 should be f Health and Mental item 27 is marked of other traumatic ev		19a. Informant's Name/Relationship (Type Shirley Church, Da	ughter	P.O.	ng Address (Street a					n, State, Zip	Code)
permit. Pages 1 and Department of He Important: If Item any injury or other stice.		20a. Method of Disposition Burial 2 Cremation 3 R '4 Donation 5 Other (Specify)	emoval from State Marde	eterv, cren	sition (Name of natory or other place emorial C	em. 4-	Date -24 - 05		oc. Location [arde1	•	ings,MD
permit. Depart Import any inj		21. Signature of Funeral Service License		Sh	Name and Addres	al Hor				, Del	19940 mar, DE
Physician /Medical Examiner bulysician and physician and the price physician and the price physician are proportional to the price physician and physician are proportional to the physician are proportional to the physician ph	dicai Examiner	23a. Part1. Enter the risease, or show shock, or heart failure. List only on Immediate Cause Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate for the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent of the consequent of	ice of): Anace of):	es in a mode of dyling	, such as ca	arulac (i resi	piratory arres			Approximate Interval Between Onset and Death
death certifi e attending I od for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deatl	ath 3	Ectopic pregnancy Other (specify)					ate of delive	ery Day Year
w requires that the s been signed by the should be detache	by P	Part II. Other significant conditions con	tributing to death but not resultin	ng in the ur	nderlying cause give	n in Part I.	:		cco use cor	atribute to th	ne cause of death?
The law ate has b page 2 sl	Completed							24a. Was an autopsy perform Yes 2	24b.	Were auto prior to co death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital.		04			eck only one,			-
hys this al di	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Outpatien Time of Injury	t 3 DOA Othe	at	28d. I	Describe how			y)
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office			ocation (Stre City or Town,		ber or Rura	l Route Number,
he Hospi in 24 hou he Funer pletely fil	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of my knowle ler: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time vestigation, in my op	e, date and inion, death	place, and d occurred at	ue to the cau the time, dat	se(s) and m e and place	nanner as st , and due to	tated. o the cause(s)
To the total	Ž	29b. Signature and title of certifier	A mp		29c. License	number	94	290	Date sign	ed (Month,	Day, Year)
Br		30. Name and address of person who co	mpleted cause of death (Item 23			bus	y M	02	1801	1	
St Regist	ate rar	31. Date filed (Month, Day Year) APR 2 2 20	32. Poistrar's Signature		Sant 1	/			-		

			1 - For State Registrar	State of	Maryland		artment rtificate			and M		giene Reg. No		15280
	Physici	an	1. Decedent's Name (First, Middle								2. Date of Dea Month		3, 20°05	3. Time of Death 7:37p M
	/Medic Examin		James Ward C 4a. Facility Name (If not institution		per)		4b. City, T	own, or	Location o	of Death	April		. County of Dea	
			Frederick Me				Fred						rederic	k
ľ	Funeral Director		5. Social Security Number 213-01-1428	6. Sex 7 1 ☑ M 2 ☐ F	. Age (In yrs. Ia 91	st birthday) Yrs.	If Under 1 Months	Days Days	If Under a	Min. J	8. Date of Birt (Month Day an . 13	h 1914	9. Bir Mary	thplace (State or Foreign ountry) 7 Land
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation							10d. Inside City Limits
	Manyla -1 sho	tor	Maryland Frede			alkers								1y Yes 2 No
	ith the Marylan or 28a-1 show a notified at	Director	10e. Street and Number				10f. Zip (10g. Cit	izen of What Co	ountry?
	eath w	Funeral	16 Maple Avenu	12. Was Deced	ent Ever in U.S	13 \		1793		nin? (Spec	ify Yes or No-		USA 14. Race - Ame	ańcan Indian
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23a or 28a-f show other treumatic event, the Medical Examinatings the notified at	by	1 □ Never Married 2√2 Mar 3 □ Widowed 4 □ Divorced	ried 1 Types 2	es?	1	f Yes, specif		Specify:	, Puerto F	cify Yes or No- tican, etc.)		Black, Whi	
5-0	"netur	etec		it's Education st grade completed)		(Give	lent's Usual kind of work	done d	urina most	of workin	g	16b. K	ind of Business	/Industry
212	d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		rain l	,				Μi	.11ing (Company
Maryland 21215-0036	d be filed intal Hygi ed other c event, I	Be	17. Father's Name (First, Middle, Claude	R.	Crum				18. Mothe Haz	-	(First, Middle,	Maiden Ey1	,	
aryl	2 should be and Mental is marked reumatic ev	O_	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street a	nd Numbe	r or Rural	Route Numbe		r Town, State,	Zip Code)
	and 2 lealth a m 27 is		Betty J. Crum/W	Vife					ue Wa	20	sville,			
nore	Pages 1 nent of H ant: If ite ary or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		ate Cel	ace of Dispo metery, cren Hope	natory or oth	ner place		/25/	2005		dsboro,	
Baltimore,	permit. Pages Department of Important: if it any injury or o		`4 □Donation 5 □ Other (S		11		. Name and						eral Ho	
<u> </u>	82 = 29		Maron C	anulle	Del	ue 1	621 O _I	poss	umtow	n Pi	ke, Fre	eder	ick, MD	21702
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on eac	m line.									Approximate Interval Between Onset and Death
}	/Medical Examiner		disease or condition resulting in death)		as a conseque		うていど	, 44	שאפיי	100	11 LURG			years
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	ence oi).								
	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C										
8760,	ate be executed hysician and the burial-transit		resulting in death, East	Due to (or	as a conseque	ence of):								
9	tificate ng phys as the	ledic	to the state of th	0.										
O. Box	that the death certific led by the attending p detached for use as t	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal o nt at time of dea	death 3	Ectopic pred Other (spec			-		2	23d. Date of del Month	ivery Day Year
S, P.	signed by	by Ph	Part II. Other significant condition			ting in the ur	iderlying cau	use give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
ord	v require been sig should t		ROWAL	NSUFFICI	ency.						1 🗆 Y	es 2	No 3□Pr	obably 4 Unknown
Division of Vital Record	The lay ate has page 2	Completed									24a. Was a autops perform	sy	24b. Were au prior to death? 1 \(\sum \text{Yes}	Itopsy findings available completion of cause of 2 ☐ No
ξ.	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Literates	atient 2 E	R/Outpatient	3 DOA	Other			Check on or			*
n of	tending Physician: leath. tor: After this certific the funeral director.	on; To	27. Manner of Death 1. ☑Natural 5 □ Pendir	28a. Date of		28b. Time of Injury		c. Injury Work	4 🗆 1401		d. Describe h		Other (Specy occurred	sity)
Siol	Attending P ir death. ector: After t by the funera	icatlo	2 Accident investig	gation			М	1 🗆 Y	es 2□N					
Div	el or Attences after death	Certification;	4 ☐ Homicide determ	ined 288. Place of building	Injury - At hom , etc. <i>(Specify)</i>	ie, iarm, stre	eet, factory,	office		28	City or Town			ıral Route Number,
	To the Hospitel or Ati within 24 hours after d To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the be Examiner: On the base and mayibe	s of examinatio	ledge, death on and/or inv	occurred at estigation, in	the time	e, date and inion, death	place, an	d due to the cad at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certific	3	0		29c.	License			2		e signed (Monti	
,	X		30. Name and address of person	who completed source	of death (line o	22a) /T 1	Oriet)	ט':	3217			(1/21/0	5
	5		R. GOUGH	Po Box	328	2 A	10000	٠٠٠	LE -	MO	2179	13		
ं	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2 2005 32. R	istrar's Signatu	ire.	Cont	,						
٠		. 1												

			For	State of Marylan	d / Department of h			•	. ~
_			1 = For State Registrar		Certificate of		Reg.	211115	15281
	Physic	ian	1. Decedent's Name (First, Middle, Last JOSEPHINE	CHER	2 0 1 2/			Day Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give			or Location of Death	4 /	9 0 5 4c. County of Death	9.36P M
	Exami	ıet	HOWARD Cour				ic A	HOWARD	COUNTY
	Funeral		5. Social Security Number 6. Se	x / 7. Age (In yrs.	last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign
	Director		222-10-4818 1L Usual Residence of Decedent	M 2 M F 82	Yrs. World Days		July 4, 19	922 SeAt	Ford Del
	yland		10a. State 10b. County	10c. City	y, Town or Location			1	0d. Inside City Limits
	8e-1s	ctor	mo. Howa:	rd	Columbia				1 ☐ Yes ANO
	with th	Funeral Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	leath ne 23	erai	6150 Foreland (Garth #208 12. Was Decedent Ever in U.	21045			U.S.A.	an Indian
9	after or Iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cubi		Rican, etc.)	Black, White,	etc.
21215-0036	72 hours after death with the Maryland neture!', or Iteme 23a or 28e-1 show dical Examinat must be notified at	d by	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No			Specify: Wh	112
15-	in 72 l	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	16b	. Kind of Business/Ind	dustry
212	d within giene. ar than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Realtor	-7		Real Est	a+e
	be filed ital Hygie d other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			200
Maryland	should be nd Mental marked o	10	Ruben Rayne				eona Ra		
Ma	id 2 sho lih and 27 ie mu traum		19a. Informant's Name/Relationship (Ty Sharon Leach/Da		19b. Mailing Address (Street				
ē,	s 1 and if Health item 27 other tr		20a. Method of Disposition	20h D	8868 Spiral	cut Unit	D, Colui	mbia, MD . Location - City or To	21045 wn, State
imo	Page nent c ent: If ury or		1 嚢 Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)	Removal from State Odo	emetery, crematory or other place of the complete of the compl			aurel, Di	Ε
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other then "neturel", or Iteme 23a or 28e-1 show Importent: If Item 23 or 28e-1 show Importent: If Item 25 or 28e-1 show Importent of the most be notified at any injury or other traumetic event; the Wadical Examinar must be notified at ance.		21. Signature of Funeral Service Licens	88		ss of Facility 25,		Po.	
	402 6 0		23a. Part1. Enter the disease, or compl	ications that caused the death				EMAIN ST	Approximate
	Pnysician		snock, or heart failure. List only of immediate Cause (Final	ne cause on each line.	a late &	ng, sacir as cardiac or	respiratory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	yeure			
	Examiner	L	Sequentially list conditions, if any, leading to immediate	Phany	eman				
7	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to [or as a consequ	renov of):				
, ,	execu an and rial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):				
8760	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai		J					
9 xo	eath certifica attending pl for use as t	/Med	IF FEMALE:	3c. If yes, outcome of pregnar	ncv				
Bo	death a atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pregnancy	/		23d. Date of deliver Month	ry Day Year
P.0	that the de ted by the a detached	hys	9 Unknown	9 Unknown					
	ires tha signed I be del	by	Part II. Other significant conditions con		Ilting in the underlying cause give	en in Part I.		o use contribute to the	
Vital Records,	w require been sig should t	Completed	(1)		^ / p/.	10000			ably 4 □Unknown
Rec	The lav ate has page 2	dmc	Do Auda	witenetin	2 Lung ou	crease	24a. Was an autopsy performed	prior to com	sy findings available pletion of cause of
ita		BeC	25. Was case referred to medical	1		26. Place of Death	1 Yes 2 (Check only one)	No 1 ☐ Yes	2 □ No
of V	Physicien: this certificaral director, p	To [To res 200		ER/Outpatient 3 DOA Other	er: 4 🗆 Nursing Hom	e 5 Residence	6 ☐ Other (Specify,	
	ding After fune	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Work	y at 28 k? Yes 2 □No	d. Describe how in		
Division	or Attending after death. Director: After in by the fune	ifica	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	me, farm, street, factory, office		f. Location (Street	and Number or Rural	Route Number,
ā	itel or A rs after ef Direc led in by	Certification;	4 Hornicide	building, etc. (Specify,)		City or Town, Sta	ate)	
	To the Hospitel or within 24 hours after To the Funerel Directory of the Funerel Directory of the filled in brompletely filled in browns.	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	1er: On the basis of examinati	viedge, death occurred at the timion and/or investigation, in my or	ne, date and place, an pinion, death occurred	d due to the cause at the time, date a	(s) and manner as sta	ited. the cause(s)
	To the within 2 To the Complet	Mec	29b. Signature and title of certifier	and manner stated.	29c. License			Date signed (Month, D	
)	- > = 0		> C/fugl	()	219	7402	(1.19.05	
	8		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	10	- 0 11		00
	Sta	to	31. Date filed (Month, Day, Year)	A Howa	urd count	y 4 km	rey H	e sperer,	Columbus
	Registr		APR 2.2 2005	32. Registrar's Signatu	good				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April Catherine Evelyn Carbone 2005 P_M 9:26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 614 Woodsman Way Crownsville Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 200XF Hours 577-32-7182 Yrs. Director 76 June 16, 1928 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Exactiner rount be notified at Maryland Anne Arundel Director Crownsville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 614 Woodsman Way 21032 U.S.A. or Itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White þ Specify 3 XWidowed 4 □ Divorced "natural" Completed raumatic avant. If a Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Conlan Josephine Magee ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unt: If itam 27 ls. John Carbone, Jr./son 614 Woodsman Way Crownsville, Maryland 21032 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page:
Department of
Important: If i
any injury or
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 4/20/2005 A □ Donation 5 □ Other (Specify) Baltimore, Maryland I neral en ce Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Opset and Death Immediate Cause (Final Metastatic Pnysician @months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of). Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? tor Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 ☐ Yes 2 ☐ No 3 robabiy 4 □Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2 X No director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 🗌 Yes 2 000 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★ esidence 6 ☐ Other (Specify) 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours or To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and Atle of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd Ste 211, MO 31. Date filed (Month, Day, Year) APR 20 State Registrar

			1 - For State Registrar	State of Mary		artment of rtificate of		nd Me		iene	15	15283
	Dhysisi		1. Decedent's Name (First, Middle, La	st)		1 10)	2	2. Date of Deat	h Dav	Year	3. Time of Death
√.	Physici /Medi		HAROCD		1004				4	8 6)5	9:15 p м
	Examir	ner	4a. Facility Name (If not institution, giv				n, or Location of			4c. County		3 3
	Funeral		Chesapeake Hospi 5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Ye	Linthic	4 Hrs. 8	B. Date of Birth			undel lace (State or Foreign
	Funeral Director			⊠ M 2□F	71 Yrs.	Months Day	ys Hours	Min.	(Month, Day, Jul. 11	, 1933	Coun	lace (State or Foreign try) NY
	pu .		Usual Residence of Decedent 10a, State 10b, County	100	c. City, Town or Lo	ocation					11	0d. Inside City Limits
	Aaryla Febor	ō		rundel	o. Oily, TOWN OF L		polis				"	1 ☐ Yes 2 ☑ No
	the N	Funeral Director	10e. Street and Number	- under		10f. Zip Cod	-		10	0g. Citizen of V	/hat Coun	
	h with	0	716 Darlow Drive				21401				USA	
	ems a	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Ong	in? (Speci	ify Yes or No-		- Americ	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TYes 2 No if Yes, Give		1 □ Yes 2 🔀			,	Specify	Whi	_
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or liems 23a or 28a-f ehow event, the Medical Examiner must be routhed at	ed b	15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual Oc	cupation			16b. Kind of Bu	siness/Inc	fustor
215	c 2 68	plet	(Specify only highest gra Elementary/Secondary (0-12)		(Give	kind of work do DO NOT use rei	ne during most tired)		7	rob. Alling of Da		
21	filed with Hygiene. Ither thai	Completed	Edinary/decordary (o 12)	4		Crypt	ologist				N	SA
Maryland	should be filed within and Mental Hygiene. marked other than matic event, the M	Be	17. Father's Name (First, Middle, Last, Harold M. Connol					's Name (Maiden Sumam	θ)	
Z Z	should nd Men marke umatic	2	19a. Informant's Name/Relationship (19h Maili	ng Address (Stre				City or Town	State Zin	Code)
Ma	nd 2 string at the transfer tr		Barbara Connolly			Darlow					401	0000)
Je,			20a. Method of Disposition		0b. Place of Dispo	sition (Name of		Apr.	te 11	20c. Location -		
Ë	Pag ent nt: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification)		Metro C	remator	Y 2	20	05	Baltim		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	. 11 2	2m B2 49	Name and Ad arranco 5 Gov.	dress of Facility & Sons, Ritchie	P.A. Hwy	. Sever	na Park na Park	Fund MD	eral Home 21146
			23a. Part1 Enter the disease, or com sheck, or bean failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of a	dving, such as o	cardiac or i	respiratory arre	est.		Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	. 5QUI	ANLOUS nsequence of):	Cell	CANC	NO	mp s	sildev	210	Onser and Death
	/Medical Examiner		105 diling in dealin)	Due to (or as a co	nsequence of):					Sini	45	
		ler	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	nsequence of):				· · · · · · · · · · · · · · · · · · ·			
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C,								
,00	be executed sician and burial-transit	Ex	resulting in death) Last	Due to (or as a co	nsequence of):							
8760,	icate b physic s the b	edical	•	d								
9 x	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	√Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of pr	regnancy					23d Date	of delive	D/
Box.	death e atter d for u	Physiclan/M	in the past 12 months?	1□Live birth 2□ 4□Pregnant at time		Ectopic pregna Other (specify)				Mor		Day Year
P.0	at the de by the a	hys	9 Unknown	9□ Unknown								
	es that igned b	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause	given in Part I,			V		e cause of death?
ord	w require been si	eted	FIFTINITI	0113 PA10	MILAI	1			1 _ Ye	7		abły 4 ∐Unknown
Records,	has by	Completed							24a. Was an autops	v n	Vere autoprior to con eath?	osy findings available apletion of cause of
Vital		e Co	25. Was case referred to medical				26 Bloom	of Dooth /	perform			2 No
Z	ysician: is certific director.	0 8	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA	Other _		Check only one 5 ☐ Reside	\/	r (Specify	HEIRICE
n of	ding Ph. After thi funeral	n: T	27, Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o		njury at Work?			w injury occurre		11-11-02
Siol	r Attendir er death. rector: Al by the fu	catle	2 Accident investigatio	n		M 1	I ☐ Yes 2 ☐ N					
Division	I or Atten after deatl Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office	Ce	28	f. Location (Str City or Town		er or Rural	Route Number,
	ours a		29a. Certifier Certifying Pr	ysicien: To the best of m	v knowledge deat	h occurred at the	e time, date and	I place an	d due to the ca	use(s) and mai	ner as sta	hate
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	Medical	(Check only 2 Medicel Exer	niner: On the basis of exa and manner stated.	mination and/or in	vestigation, in m	ny opinion, death	h occurred	at the time, da	ite and place, a	nd due to	the cause(s)
	To t To tl	2	29b. Signature and title of certifier	70 -00	100		ense number			d. Date signed		
			Mund	Vullele	11)	リジョ	3108	2		419	165	
			- / 11 -	completed cause of death	(Item 23a) (Type,	Print)	3108:	07	15 A	d MIAA	51.10	MO
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registar's	Signature		2000		/ \	V 0 0 0 10 10 10 10 10 10 10 10 10 10 10	7	1401
	Registi		ADD 19	2005	me A	Brock	,					

			1 - For Stete Registrar	State o	f Maryla	and / Depa <i>Cei</i>	artment o				giene	005	10001								
	Physic /Medi Exami	cal	Decedent's Name (First, Middle Helen 4a. Facility Name (If not institution,	Bi	llie	Має		Cassac	,	2. Date of Dea Month April	Day 21,	Year 2005	3. Time of Death 11:00 A M								
	Funeral Director	iei	12416 Bowling Str			s. last birthday) Yrs.	If Under 1 Y	Cumber	land er 24 Hrs.	8. Date of Birtl (Month, Day 03/02/1	10	Allega 9. Birthp Coun Maryl	lace (State or Foreign								
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examirar must be notified at 200e.	I Director	Usual Residence of Decedent 10a. State 10b. County MD Alleg 10e. Street and Number 12416 Bowling		10c. (City, Town or Lo	Cumber I				10g. Citizen		0d. Inside City Limits 1 ☐ Yes 2√ No								
9600	hours after death ural', or Items 2:	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or D	rces? 2∏No re	if	Vas Decedent i Yes, specify □ Yes 2 🖾	of Hispanic (Cuban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - America Black, White, e									
nd 21215-0036	e filed within 72 l I Hygiene. other then "nati	Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, L.	grade completed) College (1	-4or 5+)	(Give I	ent's Usual Oi kind of work do PO NDT use re nemaker	one during m etired)		ing	Н	f Business/Ind Iomemake	,								
Maryland	2 should be and Menta la marked aumatic ev	ToB	Charles 19a. Informant's Name/Relationshi		S	Smith 19b. Mailing	g Address (Sti	He]	.en	l Route Number	Lewi	.S	Code)								
altimore, N	ages 1 and nt of Health t: If item 27 / or other tr		Robert L. Cassady, 20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation	3 □Removal from	State	Place of Dispos cemetery, crem	sition (Name o atory or other	f place)		Cumberla Pate		yland 2 in - City or Tov									
Baltir	permit. P Departme Importan any injuri once.	1 10	4 □ Donation 5 □ Other (Special Service Li		S	unset Mem 22.	Name and Ad	dress of Fac		/2005 nms Family Cumberland	Fune ra		P.A.								
	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Che	aused the dea	Obst	r the mode of	dying, such a	s cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death 3 years								
58760,	ficate be executed by physician and street the burial-transit program is the burial-transit prog	on: To Be Completed b	Completed by Physician/Medical								Social flatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (i	or as a conse	quence of):							
O. Box	death certi e attending id tor use a			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Fet unt at time of	al death 3 □E	Ectopic pregna Other (specify,	ncy				Date of delivery Month D	y Day Year							
ords, P	taw requires that the as been signed by the 2 should be detache			Part II. Other significant conditions Dialette		ath but not re	sulting in the und	derlying cause	given in Part	l.		acco use co		cause of death?							
	The ate ha			O.	O.	O.	O	O	O	25. Was case referred to medical								led? No	prior to comp death?	sy findings available poletion of cause of	
Phys	Phys this ral di		examiner? 1 Yes No 27. Manne of Death Matural 5 Pending 2 Accident investigat	28a. Date of (Month		ER/Outpatient 28b. Time of Injury	28c. In	Oak was	ursing Hom 21	(Check only one e 5 X Resider 3d. Describe how	nce 6 🗆 O										
Ĭ N	pitat or Atte	l Certificati	3 Suicide 6 Could not determine 29a. Certifier 1 Certifying	ed 28e. Place of building	g, etc. (<i>Speci</i>					Bf. Location (Str. City or Town,	State)										
		Medical	(Check only one) 29b. Signature and title of certifier	Physician: To the taminer: On the bas and manner		,	sugation, in m	time, date and y opinion, des	nd place, ar ath occurred	at the time, da	te and place	nanner as state, and due to the	ne cause(s)								
	2		30. Name and address of person wh	o completed cause	of death (Iter	n 23a) (Type, Pr	int)	8853				2005									
	Stat Registra	<u>-</u>	Habib Chotar 31. Date filed (Month, Day, Year) APR 2 2 2005	32. Re		nsylvania		Cumber	Land, M	aryland	21502										

				partment of Health and Meartificate of Death	, ,	iene 	15285
	Physici	200	Decedent's Name (First, Middle, Last)		2. Date of Death	h	3. Time of Death
d	Physici /Media		Edward L. Carre, Sr.	<u> </u>	APRIL 18		2335 ^M
1	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
*040	*		WMHS Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Cumberland (1) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Allegany	lana (Chata a F
	Funeral Director		218 18 2090 XXM 2 F 80 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) County	lace (State or Foreign try)
	pu ,		Usual Residence of Decedent			723 MD	
	shoved	-C	PA Bedford Hyndman			10	0d. Inside City Limits
	28a-1	Director	10e. Street and Number	10f. Zip Code	1/	Og. Citizen of What Count	Yes 2 No
	3g or	I Di	183 5th Avenue	15545		USA	try?
	death	Funeral		. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - America	an Indian,
36	or lite		1 Never Married Married 1 Yes 2 No	1 Yes 2/1/No Specify:	Rican, etc.)	Black, White, e	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show than "matural" or Item of the recitied at	ed by	3 Widowed 4 Divorced Year or Dates:		1	Specify: Whi	
15	n na	plet	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	ng 1	16b. Kind of Business/Ind	ustry
212	d with giene er tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 10 Pain	ter		School main	tonanco
	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	faiden Surname)	<i>xemance</i>
yla	ould Men Marke Marke	^c	Clarence (mnu) Carre	Edith (mr		<u> </u>	
Maryland	d 2 st th and t7 Is n traun		lett. av	ling Address (Street and Number or Rural			
	s 1 an f Hea itam 3		Delores W. Carre, wife P. 0 20a. Method of Disposition 20b. Place of Disp	Box 477, Hyndman,	TA 15	545 20c. Location - City or Tov	wn, State
HO	Page nent o int: If iry or		1 ☑ Burial 2 □ Cremation 3 □ Removal from State	ematory or other place) LL Cemetery 4-22-2		Brooklyn, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, Ite Medical Exercitational Legislation and once.		21. Signature of Fineral Service License	22. Name and Address of Facility			
<u> </u>	90 E 9 9		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	Harvey H. Zeigler F			an, PA
П				Approximate Interval Between Onset and Death			
	Physician / /Medical		resulting in death)	MACH, SPLEEN AND COL	ON		Onset and Death
	Examiner		Due to (or as a consequence of): ATHEROSCLEROSIS				
	8 %	Jer	if any, leading to immediate Due to (or as a consequence of):				
	nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
90,	icate be executed physician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):				
8760,	physic the b	dical	d				
X 6	death certific e attending p rd for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	.,
. Box		iciai	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of death 5[Ectopic pregnancy Other (specify)			Day Year
P.O.	at the d by the stached	hysi	9 □ Unknown 9 □ Unknown				
Ś			Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		acco use contribute to the	
oro	w requir been si should	eted			1 ☐ Yes	s 2 No 3 Proba	bly 4 Unknown
Record	ne law has t ge 2 s	Completed			24a. Was an autopsy performe	24b. Were autops prior to com death?	sy findings available pletion of cause of
[a		e C0	25. Was case referred to medical		1 ☐ Yes 2	X No 1 ☐ Yes 2	2□ No
>		To Bo	examiner? 1 ☐ Yes 2 ▼ No Hospital: 1 ▼ Inpatient 2 ☐ ER/Outpatient	26. Place of Death		nce 6 Other (Specify)	
0 0	ding Phys		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		3d. Describe how		
sio	Attanding Pher death.	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of Vital	of or Attand after death Director: /	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, stibuliding, etc. (Specify)	reet, factory, office 28	Bf. Location (Stre City or Town,	eet and Number or Rural I State)	Route Number,
_	Hospital		29a. Certifier (Check only 2) Modical Symptotic Control of the best of my knowledge, deat	th occurred at the time, date and place, an	nd due to the cau	use/s) and manner as star	tad
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	d at the time, date	te and place, and due to t	he cause(s)
	To tha within 2 To tha complei	×	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Da	
	3		Alve 163 to Mo	D0018216	AP	PRIL 19, 2005	
	nes		30. Name and address of person who completed cause of death (Item 23a) (Type,				
	Sta		DR. STEVEN SMITH 600 MEMORIAL AVENUE 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature	SUITE 400 CUMBERL	LAND, MAR	RYLAND 2150	2
	Registra	A	APR 2 2 2005				

			1 - For State Registrar	State of Man		artment of F rtificate of		, ,	iene	E 117000
	Physici		1. Decedent's Name (First, Middle, Las Paul	Millard		Crabtre		2. Date of Death Month	Day	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give				er Location of Dea	APRIL	17, 20	
**************************************	ZAGIIII		MEMORIAL HOSPITAI			CUMBER			ALLEG.	
	Funeral Director		5. Social Security Number 6. Se 217–18–4079	7. Age (/	n yrs. last birthday) 33 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year)	Birthplace (State or Foreign Country) Mary land
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f aho	to	MD Allegar		,	mberland				1 XYes 2 No
	th the	Director	10e. Street and Number	19		10f. Zip Code		10	g. Citizen of Wi	hat Country?
	ath wi	rai	509 Eichner A	Avenue			21502		USA	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or items 23a or 28a-1 ahow of other than "natural" or items 23a or 28a-1 ahow event, the Medical Exam har mall be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	 12. Was Decedent Eve Armed Forces? 1	19/2-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Specify Yes or No- rto Rican, etc.)		- American Indian, K, White, etc. White
5-0036	72 hou	ted	15. Decedent's Edu	ucation	16a Dece	dent's Usual Occup	ation	. 1	6b. Kind of Bus	
7	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of wi	orking		,
27	filed withi Hygiene. other than	Cor	12 17. Father's Name (First, Middle, Last)		Tru	uck Driver	40.44.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4		Textile	
Maryland	a la b	To Be	Millard	В.	Crabti	ree	18. Mother's Na Virgi	ime <i>(First, Middle, M</i> Le		Robertson
ary	s 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (T)	γρθ, Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Number,	City or Town, Si	tate, Zip Code)
	1 and 2 Health tem 27		Jeanie Helmstetter /					erland, Mary	land 215	02
altimore,	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	IDITIONAL HOLLI OLDIO	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date 2	0c. Location - C	City or Town, State
	permit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens			Memorial Ga Name and Addres			LaVale,	,
g	Depi Impo		I Kabut Co	adem				Adams Family Cumberland	•	,
	Priysician /Medical		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	cerebral Bl		g, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death Weeks
	Examiner		Sequentially list conditions,	b						
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):					
'n	executing and rial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a co	ensequence of):					
08/PN	ficate be executed physician and is the burial-transit	edicai		d						
-	certific oding p	/Mec	IF FEMALE:	13c If was outcome of p	50000000					
.O. Box		Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
cords, r	law requires that the as been signed by th 2 should be detache	þ							acco use contribute to the cause of death?	
	The ate h page	Completed						24a. Was an autopsy performe	ed? prio	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No
VII	ician: Sertific actor,	Be	25. Was case referred to medical examiner?	la a si ha la				ath (Check only one)	*	
5	ding Phys	2	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ Yes 2 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	lospital: 1 X Inpatient 28a. Date of Injury	2 ER/Outpatient		4 Nursing F	dome 5 Residence		
200	ending eath. or: After he fune	cation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	28c. Injury Work M 1 🗆 Y	at (? (es 2 □ No	28d. Describe how	injury occurred	
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	pecily)			City or Town,	State)	or Rural Route Number,
	ne Hosp 124 hou ne Fune detely fi	edical	29a. Certifier 1 (☼ Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the tim estigation, in my op	e, date and place pinion, death occu	e, and due to the causurred at the time, date	se(s) and manner and place, and	er as stated. I due to the cause(s)
	To the To the comp		29b. Signature and title of certifier	2	^	29c. License	number	29d	. Date signed (A	Month, Day, Year)
Ç	TOA		Mokustiano	1. 1 Jan	les /		4865	A	PR11_ 1	197 2005
	mg.		30. Name and address of person who co	/		Print)			par I pare	,
	/	0	BARRERA, ROBUSTIA 31. Date filed (Month, Day, Year)	NO J. M.D.	500 ME		ENUE, SI	UITE 201,	CUMBERL	AND, MD 21502
	Stat Registra	٠,	APR 2 0 200	32 Aegistrar's S	S. Ap	whil				

		State of Maryland 1- State Unpend Item 23a,pt.II,27,28a	/ Department of Health and -fcertificate of Death 1-0		2005 15287
Physici	an	1. Decedent's Name (First, Middle, Last) Paul Dent			Day Year 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dear	APRIL	25, 2005 10:27a M
	ĘI	PRINCE GEORGES HOSPITAL CENTER 5. Social Security Number 6. Sex. 7. Age (In yrs. las.	CHEVERLY	F	4c. County of Death PRINCE GEORGES
Funeral Director		579-98-6459 Usual Residence of Decedent	Yrs. Months Days Hours Min		9. Birthplace (State or Foreign Country) Wash., DC
ryland	_		own or Location		10d. Inside City Limits
ith the Marylar or 28a-f show	Director	Maryland Prince George's	Seat Pleasant		1 X Yes 2 No
uth with t		10e. Street and Number 6002 Addison Road	10f. Zip Code 20743	10g.	Citizen of What Country?
death ms 2; mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (\$	Specify Yes or No-	United States 14 Race - American Indian,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inspertment of Health and Mental Hygiene. Inspertment of Health and Mental Hygiene. Inspertment if the 271 s marked other then "neturel", or items 23e or 28e-1 show any injury or other treumstic event, the Medical Examination must be notified at once.	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 🛣 No Specify:	to Rican, etc.)	Black, White, etc. Specify: Black
72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of wo	rkina 16b.	Kind of Business/Industry
withing the Man	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Waiter/Bartender		Davissa
al Hygi	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	Private en Sumame)
ylai ould b Menta marked	70	Paul Ray Dent, Sr.		Maxine Ca	
Maryland 21215-0036 of 2 should be illed within 72 hours aff th and Mental Hygiens 177 is marked other then "neturel; or treumstic event, the Medical Exame			19b. Mailing Address (Street and Number or Ru		
Baltimore, semil. Pages 1 ar Department of Hea mportent: If item 2 in y injury or other ince.			1001 Chillum Rd., He of Disposition (Name of etery, crematory or other place)		MD 20782 Location - City or Town, State
timor Pages tment of I tent: If ity		'4 □ Donation 5 □ Other (Specify) Harm	ony Memorial Park 4/3		Landover, MD
Balt permit Departr Importe any inji		21. Signatul of Funeral Service Licensee	22. Name and Address of Facility 4001 Benning Rd	Stewart Fur	
		23a. Part1. Enter the disease, or complications that caused the death. E	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate
Physician /Medical Examiner		Immediate daule (Final disease or condition resulting in death) Drowning compile. Syndrome (ATDS) Due to (or as a consequence)		odeficiency	Onset and Death
68760, lificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to mineutiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence			
b. O. Box at the death cert by the attendin	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deceded to the pregnant at time of death	5 ☐ Other (specify)		23d. Date of delivery Month Day Year
cords, F	ed by P	Part II. Other significant conditions contributing to death but not resulting Kaposi's Sarcoma of Lung	g in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Munknown
I Rec	Completed by			24a. Was an autopsy performed?	
of Vita Physicien: this certific	To Be	25. Was case referred to medical examiner? 1 □ XYes 2 □ No Hospital: 1 □ Inpatient 2X ER/i	04	th (Check only one) ome 5 Residence	6 Flother (Green)
on of ding Phys h. After this funeral dii	- L		D. Time of linjury at Work?	28d. Describe how inju	
or Attending after death. Director: After in by the fune	catic	Accident investigation 4-25-05 9	:15 A M 1□Yes 2 X □No	Subject Dro	
Divi	Certification:	28e. Place of Injury - At home, building, etc. (Specify) Residence			nd Number of Rural Boute Number, te) 6002 Addison Road ghts, Maryland
Hospi 4 hou Funei	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 X Medical Examiner: On the basis of examination and manner stated.	ge death occurred at the time, date and place	and due to the cause/	c) and manner on stated
To the within 2 To the complet		29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	-	my hi, mid	OCME	AP	RIL 26, 2005
2		30. Name and address of person who completed cause of death (Item 23a	(Type, Print) 111 Penn Street	Baltimore.	Maryland 21201
State Registra		31. Date filed (Month, Day, Year) MAY 0 2 2005			

_			1 - State of Mar State of Mar		artment of F rtificate of		•	giene Reg. No.2 A A E	I Printed	
	Dhamin		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath -	3. Time of Death	
	Physici /Medi		Michael Anthony Dougall				APRTL	17, 2005	1850 P M	
*	Examir	ner	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITA	L	4b. City, Town, o		ith	4c. County of Dea		
75	Funeral Director		216-08-6064 XDM 2DF	n yrs. last birthday) 33 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month Da	v Year) C	thplace (State or Foreign country)	
	land		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Lo	ocation				10d. Inside City Limits	
	Mary a-f sh	tor	Maryland Prince George's	Takom	a Park				1 ☐ Yes 2 No	
	th the	lrec	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?	
	ath wi	ral	6816 10th Avenue		2091	L2		USA		
036	72 hours after death with the Maryland nature!', or Items 23e or 28e-f show alloal Examirat must be notified at	by Funeral Director	11. Marital Status 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2ᡯ No	ispanic Origin? (in, Mexican, Pue Specity:	Specify Yes or No- rto Rican, etc.)	14. Race - Am- Black, Whi Specify: B]	te, etc.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent if item 27 is marked other then "naturel", or items 23e or 28e-1 show any or other treumetic event, the Marical Examination and page.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1.2 College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most of we	orking	16b. Kind of Business	,	
	filed v Hygie ther t	CO	17. Father's Name (First, Middle, Last)	Me	chanic	18. Mother's Na	me (First Middle	Automot Maiden Surname)	oile	
Maryland	ild be lental ked o	To Be	Charles A. Dougall				rgot D. (,		
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street	and Number or F	ural Route Numbe	or, City or Town, State, .	Zip Code)	
	and 2 ealth m 27 i		Margot Gray/ Mother				koma Park	k, Maryland	20912	
Baltimore,	Pages 1 ment of H ent: If ite ury or oti		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crer Gate of Hea	sition (Name of matory or other plac aven Cemete:	11	il 22, 005	20c. Location - City or Silver Spri	Town, State	
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service (Joensee	£ 5	rancigadge 00 Univer	sity Bl	s Funeral	l Home Inc ilver Sprin	g,MD 20901	
1	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	WOUND		g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death	
68760,	cate be executed physician and the burial-transit	al Examiner	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Lisease or injury that initiated events resulting in death) Last b. Due to (or as a c c. Due to (or as a c. d.						2
Box 68		Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year	
P. O.	at the d d by the etached	Physic	9 Unknown							
	w requires tha been signed should be det	by	Part If, Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.		bacco use contribute to es 2⊠No 3⊟Pr	o the cause of death?	
Division of Vital Records,	The la	e Completed	25. Was case referred to medical				24a. Was a autops perform	med? prior to death? 2 No 15 Yes	atopsy findings available completion of cause of 2 No	
<u> </u>	ysici	lo B	examiner?	2 ER/Outpatien	t 3X DOA Othe		ath <i>Check onl</i> on Home 5 ☐ Reside	ence 6 Other (Spec	cify)	
lon o	ding Ph h. After th funeral	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury Work	at ? ′es 2.⊠No	28d. Describe ho	ow injury occurred	SHOT	
Divis	Dir.	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc. (4	At home, farm, stre Specify)			City or Lowr	treet and Number or Run, State) (PSHIRE AVE ,		
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of many control of examiner: On the basis of example and manner stated	amination and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occi	e, and due to the caurred at the time, do	ause(s) and manner as ate and place, and due	stated. to the cause(s)	
•	within 3	Me	29b. Signature and title of certifier		29c. License OCME			9d. Date signed (Month APRIL 18,	h, Day, Year) 2005	
			30. Name and address of person who completed cause of death AWA RUBIO, H.P.	(Item 23a) (Type, I	Print) 111	Penn Str	eet Bal	timore, Man	ryland 21201	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 1 2005 Registrar's	Signature for	les					

			For State		of Marylar	nd / Depa		of He	ealth a		ental Hy	giene	9.0.1c.	
			Registrar 1. Decedent's Name (First, Middle)	e, Last)							2. Date of Dea	ath	U U 3 -	3. Time of Death
	Physicia		JOHN EDWARD	DOUGLAS							Month April	20 2	Year 005	1:12 P M
	/Medio Examin		4a. Facility Name (If not institution		umber)		4b. City, T	own, or	Location o	f Death	110111		inty of Death	1 1 1 1 2 2
П			Charlotte Hall	Veterans	Home		Char1	Lott	e Hal		_		Mary's	
	Funeral Director		5. Social Security Number 579–09–6288	6. Sex 1₩ 2□ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month Day Feb 1	^h 1918		place (State or Foreign ntry) 1and
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c, C	ity, Town or Lo	cation						11	IOd. Inside City Limits
	Aaryla f sho	ō	Maryland St Ma			Cha	r1otte	э На	11					1 ☐ Yes 2X No
	the 1286-	Director	10e. Street and Number	ILY 5		0110	10f. Zip 0					10g. Citizen	of What Cour	ntry?
	3e oi		29449 Charlotte	e Hall Ro	ad		2	2062	2				USA	
	deati	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U	J.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
9	after or Ite	교	1 Never Married 2 Mar	ned 1779s	2 No Sive Tattat		1 ☐ Yes 2		Specify:		,			ite
ë	hours urel',	Q p	3 XWidowed 4 □ Divorced		Dates: VVV -				tion					duate
7	within 72 hours after death with the Maryland one. then "naturel", or items 23e or 28e-f show then "naturel" or items 23e or 28e-f show in Medical Examinat must be notitled at	Completed by	(Specify only highe	nt's Education st grade completed		(Give	dent's Usual kind of work DO NOT use	done di retired)	uring most	of workir	ng	160. Kind o	of Business/In	dustry
12	withi	шо	Elementary/Secondary (0-12)	College	(1-4or 5+)		nter					Unio	n	
ğ	filed Hyg other	Be C	17. Father's Name (First, Middle,	Last)		'			18. Mothe	r's Name	(First, Middle,	Maiden Sun	name)	
<u>a</u>	utd be Aenta rked tic ev	To B	Unknown						Dais	sy Do	uglas			
Maryland 21215-0036	and h		19a. Informant's Name/Relations					•			Route Numbe			
	and seelth m 27		JoAnne M, Doug	las (Daug							425 Wa:			
Ö	ges 1 t of H if Ite or otl		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation	3 □Removal from	II SIZIO	Place of Dispo cemetery, crei			9)		ate		on - City or To	
Baltimore,	t. Partmen		4 Donation 5 Other (S		Ma:	ryland				4-27			enham,	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or Items 23e or 28e-f show any Injury or other treumetic event, the Medical Examiner must be notified at once.		21. Signature — uneral Service	Licensee	M00173		2. Name and			Ebe	rwein 1			
			23a. Part 1. Enter the disease, o	r complications that	caused the dea						White respiratory ar		MD 20	Approximate
	Dhuaisian		shock, or heart failure. Lis Immediate Cause (Final	-		2011	. 0 05	210	~	. 1				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to	o (or as a conse	quence of):	JUF	ATC	C110)N				
	Examiner		On the Control of the	1 · C	140 CAT o (or as a consec ONONE	RY A	RTER	24	0150	ASE	-			
L,	п #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	quence of):		,						
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	. /					_				
760,	ate be executed hysician and the buriat-transit	cal E	roothing in doubly said.	Due to	o (or as a conse	quence or):								
687	physicate physicate			d										
×	certif nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr							23d.	Date of delive	ery
Box	death a atte	clai	in the past 12 months?	4□Pre	birth 2 ☐ Fet gnant at time of		⊒Ectopic pre ☐ Other (spe						Month	Day Year
P. O.	that the death certifica ed by the attending ph detached for use as th	hys	9 Unknown	9□ Unk	nown									
s,	Se G	Completed by Physician/Med	Part II. Other significant condition				, ,							he cause of death?
ord	w requir been si should	ted	DIABETES MEU							5_	1 🗆 1	/es 2∐No	0 3 Prot	pably 4 🖟 Onknown
Vital Record	e taw has b	nple	DEMENTIA, -	CH120P1	HKENIA	HY/	ERTEN	1510.	ν,		24a. Was autop		4b. Were auto prior to co death?	ppsy findings available impletion of cause of
E	: The		HEPATIC FAI	LURE, S	60AMO	us cer	c CAN	CET			1 ☐ Yes	2 2 No	1 Yes	2 No
Ž.	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	71	35000		Othe			<i>(Check only o</i> ne 5 ☐ Resid		011 (0 11	
o	Phys ir this eral di	To :	1 Yes 2 No 27. Manner of Death	1 L	Inpatient 2 [e of Injury onth, Day Year)	28b. Time o		Bc. Injury Work	4 WINU		ne 5 ☐ Hesio 28d. Describe h			<u>y)</u>
on	Attending In death. ector: After by the funer	atlor	1 □ Natural 5 □ Pendi 2 □ Accident invest	ng (Mo	onth, Day Year)	Injury	м		? ∕es 2 🔲 l	No				
Division	Atte	Certification:	3 Suicide 6 Could 4 Homicide deterr	nined 200. Fld	ce of Injury - At I	nome, farm, sti	reet, factory,	office		2	28f. Location (S City or Tox		umber or Rura	al Route Number,
Ö	tel or rs afte el Dii	Cerl												
	To the Mospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 ☐ Certifyi (Check only 2 ☐ Medica one)	ng Physician: To t Examiner: On the and ma	he best of my kn basis of examin inner stated.	owledge, deat ation and/or in	h occurred a vestigation, i	it the tim in my op	e, date and pinion, deat	d place, a th occurre	and due to the old at the time,	cause(s) and date and pla	manner as s ce, and due to	stated. the cause(s)
	To the within 2 To the complet	Me	29b, Signature and title of certific	er -	,		29c.	License	number				gned (Month,	A
1			pulp	While	bar	-		DS	5090	63		04	120	12005
5	DB.		30. Name and address of person	who completed ca	use of death (Ite	om 23a) (Type,						un		
(L	Sta Registi		31 Date filed (Month, Day, Year	2 2005	use of death (Ite	nature	book)	~ 110	VIVI				
	ricgisti		Li it w		P	-/								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary			tment of Hi ificate of L		Mental Hy	/giene Reg. No	(7)	15001
	Physici /Medic		Decedent's Name (First, Middle, Lass Sara	Mildre	d		Digman		2. Date of De Month April	eath Day		3. Time of Death
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Deal			. County of Death	
			Memorial Hospital			_	Cumber1a				llegany	
	Funeral Director		210-24-0009	7. Age (li □ M 2[X]F 75	n yrs. last birth Y	rs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ay, <i>Year)</i> 1929	9. Birth Con Mary	nplace (State or Foreign untry) 7 land
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Loca	ition			_		10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	ţ	MD Allega	ny		Cumb	erland					1X Yes 2 No
	r 28a	Director	10e. Street and Number	ily		Ount	10f. Zip Code			10g. Cit	tizen of What Co	untry?
	th with		204 Seymour Str	eet			2	21502			USA	
30	be filed within 72 hours after death with the Marylar ital Hyglene. Id other than "natural", or Items 23a or 28a-1 show avent. It a Madrell Examiner must be nailfind at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	r in U.S.		as Decedent of His res, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	0-	14. Race - Amer Black, White Specify:	, etc.
15-0036	hour	ed b	15. Decedent's Ed	Year or Dates:	16a. [Decede	nt's Usual Occupa	tion		16h K	and of Business/l	White
CIZL	2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or flea aumatic avent. If a Model Examine	Completed	(Specify only highest grant Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		(Give kii life. DC	nd of work done d NOT use retired) memaker	uring most of wo	rking	100.10	Homemak	•
0	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)			110		18. Mother's Na.	me (First, Middle	, Maiden		.er
Maryland	Aenta Aenta rked tic av	O B	Milo	Н.	C1em			Ma	ry		Reed	
a	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (7		19b.	Mailing	Address (Street a	nd Number or Ri	ural Route Numb	er, City o	or Town, State, Z	ip Code)
	of Health of Health litem 27 I		Michael E. Digman				Highland D					
Baitimore,	ges 1 t of H If itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	nemoval mom state			ion (Name of tory or other place		Date	20c. Lo	ocation - City or T	own, Slate
	permit. Pages 1 Department of H Important: If ite any injury or ot		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 		MD Vet.		@ Rocky Ga		9/2005		lintstone,	
a D	Depa Impo any i		21. Signature of Funeral Service Licen	see		22. 1	Name and Address				eral Home, Maryland	
			23a. Part1. Enter the disease, or comp	olications that caused the	death. Do no	ot enter					alyland	Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Acute Myo			farction	1				Onset and Death 30 minutes
	Examiner			b	inocquonico oi	1.7.						
-	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	riséquence of	i).						
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of	f):						
2/00	s be e sician buria	alE		ď	,	,						
200	ifficate g phy: as the	edlcal		d								
O. BOX	death ceri e attendin d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death		ctopic pregnancy Other (specify)				23d. Date of deliv Month	rery Day Year
Į.	hat th ed by detach	Phy	Part II. Other significant conditions co	potributing to death but or	nt resulting in t	the und	erlying cause give	n in Part I	23a Did t	obacco u	ise contribute to	the cause of death?
ecords,	requires that the een signed by thi nould be detache	ted by	Bilateral Pneumo				onying cause give.	min aiti.		Yes 2		bably 4 Unknown
Υ.	has has	ompleted							24a. Was auto perfo 1 ☐ Yes	psy ormed?	prior to co	opsy findings available ompletion of cause of
Ta	ician: Th certificate ector, pag	Be C	25. Was case referred to medical					26. Place of Dea	ath (Check only		1 103	2 110
OI <	S S D	To E	examiner? 1 ☐ Yes 2 🖫 No	Hospital: 1 🛣 Inpatient	-	patient	3□ DOA Othe	r: 4 🗆 Nursing H	lome 5 ☐ Resi	dence (6 □Other (Speci	fy)
	ing P	lon:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Tir	me of jury	28c. Injury Work	?	28d. Describe	how injur	y occurred	
<u>s</u>	Attending or death. actor: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be		At home fare	m street		es 2 🗌 No	29f Location /	Ctraat on	d Number or Due	al Pauta Numbas
DIVISION	al or A after I Dirac d in by	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	m, silee	i, ractory, onice		City or To	wn, State	a Number of Aur	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After thi completely filled in by the funeral	edical C	29a. Certifier 1 🛣 Certifying Phyone) 2 Medical Exam	vsician: To the best of m iner: On the basis of exa and manner stated	y knowledge, imination and/	death o	ccurred at the time stigation, in my opi	e, date and place inion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1			29c. License				te signed (Month,	
	5			four			000	33280		Ap	ril 15,	2001
	MA		30. Name and address of person who o	completed cause of death	(Item 23a) (T	ype, Pri						
			Sunil K. Gupta M 31. Date filed (Month, Day, Year)			ue	Cumber1a	and, Mar	yland 2	1502		
	Sta Registr	4	APR 1 8 2001	3 Registrar's	Signature	Lagran	00					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Year 10.05 pm bernard Drees 04 2005 10 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 338 Finzel trostbur Corrett 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 129-M 2 F Yrs. 216-22-6455 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mantel Hygiena. nt: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23a or 28a-f show traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Frostburg Allegany 10e. Street end Number 338 Finzel Road 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21532-Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 N Yes 2 No
If Yes, Give
Year or Dates: WWIL 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: ۵ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 truck driver trucking 4 Department of Health and Mantel Hygis Important: If Item 27 Is merked other any Injury or other traumatic event, II once. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Albert Drees Pearl Minnick 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 Finzel Road grandson Randy Dugan 21532 Frostburg Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State # Burial 2 ☐ Cremation 3 ☐ Removal from State 12-Apr-2005 Finzel **Finzel Cemetery** Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Cirphusis Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician end I for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral diractor, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Menner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No aftar death. i Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted

To the Hosp within 24 hou To the Fune complataly fi VA

nKS

State

Registrar

(Check only

29b. Signature and title of certifier

30. Name and address of person

2005

who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Qay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Perry April 16, 2005 Arthur /Medical Duckworth 2:58 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12720 McMullen Highway Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/22/1919 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☑ M 2 ☐ F Yrs. 85 Director Mary land 214-12-3603 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD 1 Yes 2 No Director Allegany Westernport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? N N 468 Spruce Street Funerai 21562 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No 1943
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1943-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ۵ Specify White 3 X Widowed 4 □ Divorced Year or Dates 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mose Duckworth Nora Trenum 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Sandra K. Winters / daughter 12720 McMullen Highway, Cumberland, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of importent: if any injury or 5 ☐ Other (Specify) ^¹ 4 □ Donation Cumberland Crematory 04/18/2005 Cumberland, MD 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequ ence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence on Examine requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 the ettending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy perform Were autopsy findings available prior to completion of cause of death? 2∏ No 1 Yes 2 2 No 1 Tes Hospitei or Attending Physicien: 4 hours efter death. Funeral Diractor: After this certifice funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Special Residence) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Mannes of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel within 24 hours e To the Funeral Completely filled 29a. Certifie 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certain 29c. License number 29d. Date signed (Month, Day, Year) D22181 April 17, 2005 104

Gary L. Wagoner M.D. 31. Date filed (Month, Day, Year)
APR 18 2005

30. Name and address of person who complish

925 Bishop Walsh Drive, Cumberland, Maryland 21502

State

Registrar

Mause of death (Item 23a) (Type, Print)

3 Registrar's Signature

Rosetta fontaine

VOID

CERTIFICATE

2005-15294

SEE

CERTIFICATE #

2005-17763

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Catherine Doughty 8221A GORDON 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perry Hall Baltimore 17F Brookfarm Ct. If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 3-19-45 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F Hours 219-42-9504 60 Md. Director Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Md. Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 USA or itams 23a 17F Brookfarm Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify Specify: White 3 ₩ Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Co. Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be James Doughty Margaret Greely Doughty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 E. 31st Street, Baltimore, Md. 21218 Steven Gordon, Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 70 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = ō Department of important: If any injury or 4-23-05 St. Stephens Cem. Delmar, De. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, De. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Due to (or le a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions Physician/Medical Examiner Due to for as a consequence of Tany, leading to inmedicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the t IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.0. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2) No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes the Hospital or Attanding Physician: director, 25. Was case referred to medical examiner? / 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ▼ No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after

To the Funerel Dira

completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cau

APR 2 2 2005

Belan

9618

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

gistrar's Signature

20/05

Md 21236 Howard H. Bond

			State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep Registrar Amend Item 10a per FH, G844, 96	partment of Health and Mei 115/05dhb Irtificate of Death	ntal Hygiene	15296
	Physici		1. Decedent's Name (First, Middle, Last) Raymond Thomas Gibson, Ir.		Date of Death Month Day Yea	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital	4b. City, Town, or Location of Death	4c. County of Do	eath
	Funeral Director		5. Social Security Number 174 12 6414 Usual Residence of Decedent	Months Days Hours Min.	Date of Birth (Month, Day, Year) 3-12-1921 P.	Birthplace (State or Foreign Country) A
	iryland thow		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	he Ma	ecto	— PA MD Allegany Cumberla 10e. Street and Number		10 000	1 Tes 2 No
	3a or	I Dir	13301 Winchester Road SW, Lot EE	10f. Zip Code 21502	10g. Citizen of What	Country?
936	be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "neturel", or items 23a or 28a-f show event. The Medical Evarili at must be notified at	by Funeral Director		. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- lan, etc.) 14. Race · Al Black, W	merican Indian, hite, etc. White
2-0	72 ho	eted	(Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Busine	ss/Industry
21215-0036	filed within Hygiene. other then "	Completed	Florontany/Secondary (0-12) College (1-4er 5+)	DO NOT uso retired) il operator	Retail	
	should be filed with nd Mental Hygiene marked other the imatic event, Inc.	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maiden Sumame)	
Maryland	2 should be ti and Mental H Is marked ot raumatic ever	2	Raymond T. Gibson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Bessie (r.	nnu) Lape	Zio Codel
				301 Winchester Road S	· ·	
altimore,	9° = 5		20a. Method of Disposition 20b. Place of Disposition 1 Rurial VIVI cremation 3 Removal from State 20b. Place of Disposition cemetery, cre		20c. Location · City	or Town, State
Balt	permit. Pag Deportment Importent: any njury o			22. Name and Address of Facility larvey H. Zeigler Fur	neral Home, Hynd	dman, PA
			23a. Part : Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	24THMIA		Minutes
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	Herry Failor		Chechalin
.O. Box 6	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of o	delivery Day Year
rds, P	quires that n signed b uld be deta	þ	Parth, Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death? Probably 4 □Unknown
Il Records,		Completed	ENCOPHALOPOTHY		autopsy prior t performed? death	autopsy findings available o completion of cause of ?
Vital	Physicien: The this certificate al director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (C	***************************************	
of	ding J. After funer	atlon: To	27. Manner of Death 1 Matural 5 Pending 2 Accident Ac	ant 3 DOA 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Si	oecify)
Division	el or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f.	. Location (Street and Number or City or Town, State)	Rural Route Number,
	To the Hospitel or All within 24 hours after of To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, and nvestigation, in my opinion, death occurred	I due to the cause(s) and manner at the time, date and place, and d	as stated. ue to the cause(s)
	To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	D 2005
	noh.		30. Name and address of person who completed cause of death (Item 23a) (Type DR, Robert Wellk 900 Seton		erlaid, MD	21502
1	Sta Registi		31. Date filed (Month, Day, Year) APR 1 4 2005 32. Registrar's Signature			

ivi 0	s D. Ha 5-02563	ıgi	ns 1- For State Registrar	State of	Maryland / De	partmen ertificat					giene 0	05	15297
			1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath		3. Time of Death
	Physici /Medio		SHAVIS	D. H.	AGINS					April	12.	Year 2005	07:37 A ^M
	Examir		4a. Facility Name (If not institution,	give street and num	ber)	4b. City,	Town, or	r Location	of Death	1	4c. County		07.57 11
			5511 Keppler Ro	ad				Hill	S		Princ	e Geo	orge's
	Funeral		· ·	5. Sex 7 152 M 2 ☐ F	. Age (In yrs. last birthda 27 Yrs.	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	h /, Year)	9. Birth	olace (State or Foreign
	Director	ļ	Unknown Usual Residence of Decedent	2 2 .	2 / Yrs.				L	8. Date of Birth (Month, Day June 4	,1977	Ma:	rýland
	land ow		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	Mary -1 sh	ţ	Md Montgo	mery	Silve	er Spi	ring	3					XXes 2 ☐ No
	r 28a	Director	10e. Street and Number	_		10f. Zip	Code				10g. Citizen of V	Vhat Cou	ntry?
	h with	O E	8501 11th	Avenue		20	0903	3			U.S.A		
	within 72 hours after death with the Maryland ane. than "natural", or itema 23e or 28e-1 show te Madical Exeminer must be notified at	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S. 1:	B. Was Deced	dent of H	ispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)		e - Americ	can Indian,
9	after or its	正	Never Married 2 Married		2. [T xNo	1 Yes				ricali, etc./		k, White,	etc.
8	ural',	d b	3 Widowed 4 Divorced	Year or Dat	es:						Specify	B.	lack
21215-0036	nati	Completed by	15. Decedent's (Specify only highest		16a. De (Gi	cedent's Usua ve kind of wo . DO NOT us	nk done o	ation during mos	t of work	ing	16b. Kind of Bu	ısiness/In	dustry
12	withir ene. than	E G	Elementary/Secondary (0-12)	College (1-	4or 5+)	Paint		"			Priv	ate	
	filed with Hygiene. other than ant, tre N	ပိ	12th Grade 17. Father's Name (First, Middle, La	lst)				18. Mothe	er's Nam	e (First, Middle,	Maiden Sumam		
an	ould be Mental arked o	To Be		Clark					wan				
Maryland	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship	o (Type, Print)	19b. Ma	iling Address	(Street a				r, City or Town,	State, Zip	Code)
	1 and 2 Health a tem 27 is		Lawana Hag	ins (Moth	ner) 25	Nati	ive	Danc	cer	Ct, Da	rnesto	wn,	Md
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic evant, the Macical Examinar must be notified at Angles.		20a. Method of Disposition		20b. Place of Dis	position (Nari rematory or o	ne of ther plac	e)		Date	20c. Location -	City or To	own, State
Ĕ	Page nent and in it. It is		1 Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe	cify)	Gate of				1/19	/2005	Silver	Spi	cing, MD
alti	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Envice Lic	cens	16			ss of Facili	y Sn	owden	Funera	1 H	ome, P.A.
8	89728		Course 1	5 xua	eer							lle,	,MD20850
			23a. Part 1. Enter the disease, or co shock, or head failure. List or	omplications that can nly one cause on ea	used the death. Do not e	nter the mod	e of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a	Multip	he 6	INN	teels	- 4	Dund	2	- 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consequence a):				•				
	Examine	Ļ	Sequentially list conditions,	b. Due to to									
	ed	Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury	Die to go	ras a consequence of):								
	xecut and Il-trar	xan	that initiated events resulting in death) Last	c	r as a consequence of):								
8760,	The law requires that the death certificate be executed site has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	licai E		`	,.								
687	ficate phys s the	g		d									
Вох	death certifics attending ph d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy						23d. Date	e of delive	erv
B.	death e atte d for	icia	in the past 12 months?	4□Pregna	nt at time of death	B⊟Ectopic pr i⊟ Other (sp					Mor		Day Year
0	at the de by the a	hys	9 Unknown	9□ Unknov	vn								
S, D	res that igned b	by P	Part II. Other significant condition	s contributing to dea	th but not resulting in the	underlying ca	ause give	en in Part I.		23e. Did to	bacco use contr	ibute to th	ne cause of death?
ord	w require been signature									1 □ Y	es 2 No	3 🗌 Prob	ably 4 Unknown
Record	has be	ple								24a. Was a		Vere auto	psy findings available impletion of cause of
		Completed								A perfor	med? d	leath?	2 No
Vital	Phyaician: The this certificete h ral director, page	Be (25. Was case referred to medical examiner?					26. Place	of Deat	(Check only or	10)		
of \	Phyale this or	2	1 X Yes 2 □ No		patient 2 ER/Outpat			4 NU	ırsing Ho	me 5 Resid	ence 6 - the	er (Specif	scene
	ding P. After I	lon:	27. Manner of Death 1 □Natural 5 □ Pending		Injury 28b. Time lnjury Injury		8c. Injury Work			28d. Describe h	ow injury occurr	be	
Sic	Attanding r death. actor: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could no	the The	105 74		1 🗆 '	Yes 21		Subjec	18/01		
Division	or At offer Dirac in by	Certification:	4 Homicide determine	ad 280. Tace o	of Injury - At home, farm, g, etc. (Specify)	street, factory	, office -			28f, Location (S	treet and Numbe , State)	or Or Rura	l Route Number,
	pours cours (illed		29a. Certifier 1 ☐ Certifying	Physician: To the h	est of my knowledge, de	ath occurred	at the tim	o data an	d place	2011 f	eper	10	20140
	To the Hospital or Attano within 24 hours efter death To the Funeral Diractor: completely filled in by the	edicai		taminer: On the bas	is of examination and/or	investigation,	in my or	oinion, dea	th occurr	and due to the c ed at the time, d	ause(s) and mai late and place, a	nner as si ind due to	ated. the cause(s)
	orthin orthin	Me	29b. Signature and title of certific	1)		290	License	number	_	2	9d. Date signed	(Month,	Day, Year)
	C > F 0		· / /	Vin	RIPPLE FO	1	OC	CME			April 1	3, 20	005
	V		30. Name an address of person wh		A COLUMN TO THE PARTY OF THE PA	e, Print)							
			DR. LAROH	LUCKE		1	.11 I	Penn S	Stre	et Balt	timore,	Mary	land 21201
	Sta		31. Date filed (Month, Day, Year)	nns Phe	gistrar's Signature	20 E							
	Regist	rar	APR 212	Store	w A AP	349.6							

			1 - For State Registrar	State of Maryland / E	Department of F Certificate of			ene 005	15298
Ì	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
1	/Medic	al	John Harre 4a. Facility Name (If not institution, give str		4h City Town	or Location of Death	April April	15,2005 4c. County of Deat	5:35am M
	Examin	er	5511 Garden Dr.	eet and numbery	Clint			•	
ı	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bin		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Prince Ge	Porges Applace (State or Foreign untry)
L	Director		300-22-7113	^{4 2□ F} 74	Yrs. Moritis Days	Hours Win.	Novembe	r 28,1930	Mississippi
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	or Location				10d. Inside City Limits
	Mary I-f sh	to	MD Prince Geo	orges Clint	on				1 XYes 2 □ No
	h the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	death with the Maryland ms 23a or 28e-f show Littlet be follfied at	rai D	5511 Garden Dr.		20735	5		United Sta	ites
	er des Itams	Funeral		. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian,
0000	Ir, or	by F	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🗓 No	Specify:		Specify:	Black
5	2 hou		15. Decedent's Educa	tion 16a.	Decedent's Usual Occup	pation	11	6b. Kind of Business/l	ndustry
7	ithin 7 Ie. Ien "r	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most of work d)	ing		•
7	led wi		47.5.0.1.41	4	Teacher			DC Public	Schools_
Jana	i be fi	Be	17. Father's Name (First, Middle, Last) John Harrell St	•			e (First, Middle, Ma	,	
	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Type		. Mailing Address (Street		Mae Ewin		in Code)
2	nd 2 s lith ar 27 is r trau		Juanita Harrell		511 Garden				ip Code)
a,	is 1 au of Hea item othe	1 3	20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place	CELED TO SERVICE OF THE PERSON		Cc. Location - City or	Town, State
Ē	Page nent c ant: If ury or		1 X Burial 2 □ Cremation 3 □ Rer '4 □ Donation 5 □ Other (Specify)	noval from State	ection Ceme	1	0-2005	Clinton MD	
Daillinor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Evantral Entral Legicolling at SRCs.		21. Signature of Funeral Service Licenteee		22. Name and Addre	ss of Facility A1	exander	S.Pope Fun ton DC 200	eral Home
E			23a. Part1. Enter the disease, or complica shock, or heart lailure. List only one	ations that caused the death. Do r					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lu	na Ca	encer			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of					OMICHIA
		Je.	Sequentially list conditions, b.	Due to (or as a consequence of	of).				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					-	
Š	an an rial-tr		resulting in death) Last	Due to (or as a consequence of	ol):				
0/00	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d.						
ŏ XO	ertific ding p	0	IF FEMALE:	c. If yes, outcome of pregnancy					
0	attender for us	Physician/M	in the past 12 months?	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of deli- Month	/ery Day Year
j.	the d sy the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	3 Gottlei (specily)				
J.	es that the death certification of the attending for detached for use as	by P	Part II. Other significant conditions contr	ibuting to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
cords	w require been sk						1 ☐ Yes	2 □ No 38 Pro	bably 4 Unknown
S S	has be	ompleted					24a. Was an autopsy	24b. Were aut	opsy lindings available ompletion of cause of
=	10 1	Con	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				performs	d2 death? No 1 ☐ Yes	
Vilai	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:	tractions 25 pos Oth	20	(Check only one)		
5		: To	1 Yes 2 No	28a. Date of Injury 28b. T	ipatient 3L DOA	4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 □Other (Spec	fy)
SION	Attending ir death. ector: After by the fune	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Ir	ime of 28c. Injury Wor	k? Yes 2□No		,- ,	
<u> </u>	r Atte er deg recto by th	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		281. Location (Stre City or Town,	et and Number or Rui	al Route Number,
5	itel or ref DI led in	O							
	To the Hospitel or Attendi within 24 hours after death. To the Funeref Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) Certifying Physic Medical Examine	tian: To the best of my knowledge r: On the basis of examination and and manner stated.	, death occurred at the tin isor investigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	Vithi To tl	Σ	29b. Signature and title of certifier	/	29c. Licens			. Date signed (Month,	
1			MSW	your MI)	1940	5246	A	pril 18	2005
K	-(10)		30. Name and address of person who com	pleted cause of death (Item 23a) (Type, Print)	we	don	pril 18, MD 2	0603
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2 2005	Registrar's Signature	book	<i>y</i>	0		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death-Day **Physician** Month 19, Rafael T. Hevia April 2005 11:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 7135 Carroll Avenue Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**™**M 2□F 579-38-7328 Yrs. Director 93 Jan. 18, 1912 Cuba Usual Residence of Decedent with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23a or 28a-f show any injury godiner treumetic event, the Medical Evanthat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Montgomery Takoma Park Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7135 Carroll Avenue 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Cuban Baltimore, Maryland 21215-0036 White Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 Waiter Food Service 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miguel Tenorio Caridad Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Estela O. Hevia/ Wife 7135 Carroll Avenue, Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 22, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park * 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 4. Ken SKile 500 University Blvd, W, Silver Spring, MD 20901 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arrhythmia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 🗋 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Metastatic Prostate Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate has autopsy performed? 2 □XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen M. Kango, M.D. 7610 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 15

		1	For State Registrar	State of Ma	ai yianu		tificate				R	eg. No.	· ·	10000
	Physicia		Decedent's Name (First, Middle, Las AA	RON HOOKS							ate of Deat	18 ^{Day} 20	OŠ ^{ear}	3. Time of Death 7:00 P M
	/Medic Examin		a. Facility Name (If not institution, give	street and number)				own, or L	ocation of D	eath			ty of Death	
	Funeral Director	1	5. Social Security Number 6. S		e (In yrs. las	st birthday) Yrs.	If Under 1 Months	Year	If Under 24 Hours	Hrs. 8. D. (A	ate of Birth Jonth, Day,		9. Birth	place (State or Foreign intry) yland
	D		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Maryli -f sho	ţċ	Maryland Talb	ot			Eas	ston						1 ☐ Yes 2 X No
	h with the 23a or 28e at be not	Funeral Director	10e. Street and Number 7080 Lauren La	ne, Apt 30	4		10f. Zip 0	^{Code} 21601			1	l0g. Citizen o	f What Cou USA	intry?
220	s 1 and 2 should be filed within 72 hours effer death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural," or iteme 23a or 28e-f show other traumatic event, the Musical Examiner must be notified at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 X			Was Decede If Yes, specif 1 Yes 2			? (Specify) Puerto Ricar	Yes or No- n, etc.)	В	ace - Amer lack, White sify: Bla	
213-0030	thin 72 hou e. an "nature Moulce!	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5	i+)	(Give life.	dent's Usual kind of work DO NOT use	k done du e retired)	ion iring most of	f working		16b. Kind of		
V	e filed wi al Hygien other th		unknown 17. Father's Name (First, Middle, Last)			unknow		18. Mother's	Name (Firs	st, Middle,	Maiden Sum	nknow	m
yland	uid be f Aental F rked of tic eve	To Be	Gregory Hathawa						Const	ance 1	Delor	es Hoo	ks	
Mary	2 should and Men is marke		19a. Informant's Name/Relationship (r, City or Tow		
and a	1 and Health em 27 other tr		Constance Hooks / 20a. Method of Disposition	mother	20b. Pla	ce of Dispo	osition (Name	e of		Date		de Gra 20c. Location		D 21078 Fown, State
ē	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of the Co				matory or oth ris &			4/28/	05	West C	heste	er, PA
Baltimore,	permit. Pages 1 Department of H importent: If ite eny injury or ot once.		21. Signature of Funeral Service Lice	cott			2. Name and Lisa 552	a Sco Lewi	ott Fu is Str	neral	Home Havre	P.A. de Gr	ace,	MD 21078
١	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each li	the death.	Do not en	ter the mode	of dying,	, such as car	rdiac or res	piratory arr	rest,		Approximate Interval Between Onset and Death
ľ	/Medical Examiner		disease or condition resulting in death)	Due to (or as	a conseque	ence of):	<u> </u>	<u> </u>		<u> </u>				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of):								
68760,	ificate be executed g physician and as the burial-transit	edicai Exa	resulting in death) Last	Due to (or as	a conseque	ence of):								
_	TO M	Medi	IF FEMALE:	220 If you gutcome	of preapage	1011						024	Data of dali	
.O. Box	Hospitel or Attending Physicien: The law requires that the death certi 24 hours eiter death. Funerel Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	□Ectopic pre □ Other (spe						Date of deli Month	Day Year
٥.	uires that the dei signed by the a id be detached f	by	Part II. Other significant conditions	contributing to death b	out not resul	lting in the u	underlying ca	ause give	n in Part I.		23e. Did to			the cause of death?
Division of Vital Records,	he law require e has been sig age 2 should b	Completed								_			b. Were au prior to d death? 1 Yes	topsy findings available completion of cause of
Ita	ian: T artificat ctor, pa	Be Co	25. Was case referred to medical examiner?						26. Place of	f Death (Ch			73.00	
of <	Physic this ce al dire	မ	1X Yes 2 No 27. Manner of Death	Hospital: 1 Inpati	- 23	R/Outpatie		8c. Injury	4 19015			lence 6 0		cify)
on	nding ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	Year)	Injury		Work'	9 2 No	1	Sil	ject	sta	bood
Divis	To the Hospitel or Attending Physicien: The law within 24 hours efter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not determined	200. FIACE OF III	tc. (Specify	me, farm, st	treet, factory			28f. I	Location (S City or Tow	Street and Nu n. State)	mber or Ru	ral Route Number 904
	he Hospitel n 24 hours e he Funerel I pletely filled	edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best miner: On the basis of and manner s	of examinati	vledge, dea ion and/or ii	nvestigation,	in my op	inion, death	place, and o occurred a	t the time, o	date and plac	e, and due	to the cause(s)
•	To the within 2 To the complet	M	29b. Signature and title of certifier	france	-Pag	De.		: License	number			29d. Date sig APRIL		
	2		30. Name and address of person who	tronica	- 101	LAK	Print)	11 Pe	enn St	reet	Balt	imore	, Mary	7land 21201
	- St Regist	ate	31. Date filed (Month, Day, Year)		rar's Signat	ure do	de							

DHMH 17 Rev 1/2001

YASKINS, DOGTA

			For State Registrar	State of M	laryland / D	epartment Certificate			Mental Hy	giene	1005	15302
	Physici		1. Decedent's Name (First, Middle, Huey Aaron Hold	•					2. Date of Do Month ALR	eath	7, Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, Saint Josep	give street and number h Medical	. Center		Town, or	Location of Death			County of Dea	
	Funeral Director		464-66-4880	6. Sex 7. A 1 1 X M 2 □ F	ge (In yrs. last birth 64 Y	day) If Under 1 Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 05/18	rth a <i>y, Year)</i> /1940	9. Bir LA	thplace (State or Foreign buntry)
	show		Usual Residence of Decedent 10a. State 10b. County	<u>, ,</u>	10c. City, Town	or Location		-				10d. Inside City Limits
	the Ma 28a-1	recto	PA York 10e. Street and Number		Seven V	alleys	Code			10a. Cit	izen of What Co	1 Yes 2X No
	h with	I DI	162 Lindy Road			1736				USA		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show or other traumatic event, the Modical Examinate institution of the modified in the Modical Examination.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces ad 1 Tyes 2 Tild Yes, Give Year or Dates:	? (No	13. Was Decede If Yes, speci		spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No Decify Yes or No Decify Yes or No Decify Yes	0-	14. Race - Ame Black, Whit Specify:	
21215-0036	within 72 ho one. ihan "natur o W. Jical	mpleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	life. DO NOT use	k doné di e retired)	uring most of wor	king		ind of Business	
	filed v Hygie other t	e Co	17. Father's Name (First, Middle, L	ast)	FIL	ght Oper	-	18. Mother's Nan	ne (First, Middle		rline Sumame)	
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than " traumatic event, the Men	To Be	Ernest Holden						n Sharp			
Mar	nd 2 shallth and 27 ls m		19a. Informant's Name/Relationshi Linda Holden/ W					nd Number or Ru 1 Seven				Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tra once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 ☐Removal from State	20b. Place of I cemetery,	Disposition (Name or other or other Ceme	e of her place) 1	Date / 2005	20c. Lo	ocation - City or	
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service L	icensee		22. Name and	Address	s of Facility Ro	bert E.	Evai	ns Fune	
	Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. LEFT	HEART F	AILURE	of dying	, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death 48 HOURS
	Examiner				s a consequence of IARY ART		SEAS	BE.				YEARS
8760,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of							
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 ☐ Ectopic pre 5 ☐ Other (spe					23d. Date of del Month	ivery Day Year
Δ.	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to death	but not resulting in t	he underlying ca	use give	n in Part I.	23e. Did			othe cause of death?
Il Records,	ysician: The law requisions certificate has been director, page 2 should	Completed							24a. Was auto perfe 1 🗌 Yes		prior to	topsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 46			Othe	26. Place of Dea				
of	ing Ph h. After th tuneral	atlon: To	1 ☐ Yes 2 🔏 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigs	28a. Date of Inj (Month, Da		ne of 28	c. Injury Work	at Nursing n	ome 5 ☐ Resi 28d. Describe		6 □Other (Spe y occurred	cify)
Division	To the Hospital or Attano within 24 hours after death To the Funeral Diractor: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	280. Place of In	njury - At home, farn tc. (Specify)	n, street, factory,	office		28f. Location (City or To	Street an wn, State	d Number or Ru)	ıral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner s	of examination and/	death occurred a or investigation, i	it the time in my opi	e, date and place, inion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	with To t	Σ	29b. Signature and title of pertifier	/ na	D	29c.	License	number		29d. Dat	e signed (Monti	
				/ /2	V .		0005	57593		Apr	1 10	, 200)
			30. Name and address of person w	7505	OSLER D		BUIT	E 410,	TOWSO	N,_1	MARYLA	ND 21204
	Sta Registi		31. Date filed (Month, Day, Year) APR 2		rar's Signature	South	0					

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 827M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1000 Lee Jackson Drive Lothian 8. Date of Birth Aug. 29, 1953 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 SF Director 51 181-44-5790 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Medical Examinar rount be notified at 1 Yes 2 No Anne Arundel Lothian Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20711 1000 Lee Jackson Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) health care Pharmacist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jiny or other traumatic event 9DRS. Be Aleen Connor ပ္ James Hartland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Lee Jackson Dr. Lothian, MD 20711 John Hilliard / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD St. Mary's Cemetery 4-22-2005 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Lingsee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) terioscleratic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the buriat-transli and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d Date of delivery 3 DEctopic pregnancy signed by the atte Month Day Year 4□Pregnant at time of death 5 Other (specify) the / 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 100 certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?

Ya Yes 2 \(\) No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death Director: Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier eputy of person who completed cause of death (Item 23a) (Type, Print) JONES mo 31. Date filed (Month, Day, Year)

APR 2 State Registrar

			1 - For State Registrar	tate of Maryland / D	Department of F Certificate of I			ene g. No. 2 1 1 5	IFOOL
			1. Decedent's Name (First, Middle, Last)			1	2. Date of Death Month;		3. Time of Death
	Physicia /Medic		Mildred S. Joseph				4	Day Year	1845 M
	Examin		4a. Facility Name (If not institution, give street	t and number)	4b. City, Town, o	r Location of Death		4c. County of Death	
			Peninsula legional	nedical Center	Sali	Shird		Wicon	ico
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birt	thday) If Under 1 Year Months Days	If Under 24 Hrs. 8	B. Date of Birth	9 Rinth	place (State or Foreign
	Director		217-30-9304 ^{1□ M}	2LAF 72	Yrs.	7	(Month, Day, -24-32		DE.
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	a or Location				10d Inside City Limits
	anyla sho	<u>_</u>	_		_				10d. Inside City Limits 1 ☐ Yes X☐ No
	Ba-f	ecto	De. Sussex	Laure			- 1		
	with t	Director	10e. Street and Number	- 1	10f. Zip Code		10	g. Citizen of What Cou	intry?
	s 23	rai	12347 Whitesville		19956		7 11	USA	
	s filed within 72 hours after death with the Maryland at Hygiene. other then "neturel", or items 23e or 28e-f show vent, tre Medical Examiner must be notilited at	Funeral		Vas Decedent Ever in U.S. Armed Forces? ☐ Yes 2 1 No	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto R	ity Yes or No- ican, etc.)	14. Race - Amer Black, White	
36	rs aft	by F		f Yes, Give fear or Dates:	1 ☐ Yes 2X No	Specify:		Specify:	√hite
21215-0036	ture	ed	15. Decedent's Education		Decedent's Usual Occup	ation	1	6b. Kind of Business/Ir	dustry
15	n "ne	Completed	(Specify only highest grade co	mpleted)	(Give kind of work done life. DO NOT use retired	during most of working	9	00. 14.10 01 5001100011	idustry
212	with jiene r the	E o	Elementary/Secondary (0-12)	College (1-4or 5+)	Seamstress			Garment Co	
	Hygotha otha	BeC	17. Father's Name (First, Middle, Last)	\\		18. Mother's Name (
Maryland	lid be lenta ked ic ev	To B	Ed Savage			Dorothy	Tyre Sa	vage	
ary	shound N	-	19a. Informant's Name/Relationship (Type,	Print) 19b.	. Mailing Address (Street	and Number or Rural	Route Number,	City or Town, State, Zi	o Code)
	nd 2 alth a 27 is		Ralph N. Joseph, Hu	sband 1	2347 Whites	ville Rd.	Laurel,	De. 19956	
ē,	s 1 and 2 of Health a item 27 is	- 2	20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place	Da		0c. Location - City or T	own, State
9	Page ent o nt: if ry or		¹X☐ Burial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	varirum State	Hill Cem.	4-21-0	05	Laurel, De	⊇.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28a-1 show eny injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22. Name and Addres			· · · · · · · · · · · · · · · · · · ·	
_	g 0 = 9		www		700 W. St.	Laurel, D	e. 1995	6	
п			23a. Part1. Enter the disease, or complication shock, or learn failure. List only one complete.	hs that caused the death. Do rause on each line.	not enter the mode of dyin	ig, such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Humstensin	+ Cadiaira	scular	Ds.		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of	of):				
Р	Examiner		Sequentially list conditions, b	144	rentension				
	pe #	Examiner	il any, leading to immediate cause. Enter Underlying	Due to (of as a consequence	ኅ):				
	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	Dua 4- (-0.				
50,	licate be executed physician and s the burial-transit	E		Due to (or as a consequence of	or).			Ī	
68760,	ate b	edicai	d						
_	entiffic ding p		IF FEMALE:						
Вох	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/M	in the past 12 months?	f yes, outcome of pregnancy	3 Ectopic pregnancy	,		23d. Date of deliv Month	ery Day Year
o.	the a	sic	1 Vas 2 No	4□Pregnant at time of death 9□Unknown	5 Other (specify)				
P.O.	hat the		Part II. Other significant conditions contrib	iting to death but not resulting in	the underlying cause can	en in Part I	23e Did toba	acco use contribute to t	he cause of death?
Records,	signe signe	l by	Hussell		and dispersion of the control of the	orrar raici.		s 2 □ No 3 □ Prol	
0.0	requ	etec	119/2011/18011/18				-		
3ec	elaw hasi je 2 s	Completed					24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
		Ö	<u> </u>				perform		2 🗆 No
Viital	Attending Physician: The la ir death. actor: Atter this certificate hav by the funeral director, page 2	Be	25. Was case referred to medical examiner?	ital:	Oth	26. Place of Death /	Check only one)	
of	Phys this al dir	4	1 1 1 1 1 1 2 2 E 1 1 4 0	1 _Inpatient 2 KENOU		4 Nursing nome		nce 6 Other (Special	(y)
Ž	ding 1 I. After funer	on	1 ☑Natural 5 ☐ Pending		ime of 28c. Injury		d. Describe nov	v injury occurred	
Sic	tend death tor:	cat	2 Accident investigation 3 Suicide 6 Could not be	a Di attai Alb (Yes 2 No	4 1		10
Division of	i Sir de	Certification:	4 Homicide determined	Be. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	20	City or Town,	eet and Number or Rur State)	ai Houte Number,
_	Hospitei 24 hours a Funerai l		29a. Certifier 1 Certifying Physicia	n: To the heet of my knowledge	double convered at the tree	no data and place an	d due to the co.		
		edical	(Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and and manner stated.	d/or investigation, in my o	pinion, death occurred	I at the time, dat	te and place, and due t	nated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	Harrior Status.	29c. License	e number	29	d. Date signed (Month,	Day, Year)
	F 3 F 8		1 / / / / / / / / / / / / / / / / / / /	•		4986		4/19/10	,
r	103				Type Print	11"		111103	
	40		30. Name and address of person who complete the server of	11 560 Rivers	Type, Print) Le Dr. B10	1 Salubu.	ry Md.	21801	
	Sta	te	31. Date filed (Month, Day, Year)	32. gistrar's Signature			-		-
	Registr		APR 2 2 2005	Beau &	locate.				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05 AN ARTHUR WILLIAM JOHNSON, JR. 18,2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CUMBERLAND HOSPITAL SACRED If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-36-8268 Vrs MARCH 4,1939 MARYLAND 66 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No CUMBERLAND MD ALLEGANY Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number
451 WAVERLY TERRACE
-\$%!-WAVERLY TERRACE ö U.S.A. CUMBERLAND or Items 23a Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 162-164 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specity: Specify: WHITE Completed by 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other traumatic event. If a Max College (1-4or 5+) LABORER & CARETAKER CEMETERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY C. NAUGHTON ARTHUR WILLIAM JOHNSON, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 223 EMILY STREET - CUMBERLAND, MD 21502 DEBRA DARBY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State CUMBERLAND CREMATORY 04/19/2005 CUMBERLAND, MD * 4 □Donation 5 □ Other (Specify) Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 202 GREENE STREET, CUMBERLAND, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) msocard **Physician** dan /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 Ectopic pregnancy 2 Fetal death Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown م 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? Coronar 24a. Was an autopsy performed 2 No 1 Yes 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physiclen: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 ⊟Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year)
APV 18 2005 29c. License number 29b. Signature and title of certifier 6/IVA Minam Jemaan SACRED HEARTHOSPITAL, Cumbular MD 21502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSAM SEMAANIMA MAN 31. Date filed (Month, Day, Year) Registrar's Signature State APR 1 9 2005 Registrar

DHMH 17 Rev 1/2001

Amend Tem 29c, a per Dr., G843, 05/19/05dhb State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 2005 Maria Teresa Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Doctors Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 11/22/1939 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Yrs Washington DC Director 65 218-38-8344 Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiners wat be retified at 1 X Yes 2 □ No Directo Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9129 Alcona Street 20706 death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 XNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. o filed within 72 hours after de I Hygiene. Other than "natural", or items 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 12 Own Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Be Rose Marie Gallagher Thomas Joseph Kane 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) importent: If item 27 is any injury or other treun Horace A. Jones/ Husband 9129 Alcona Street Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 4/21/2005 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit The law requires that the death certificate be executed Cancer of the Lung Due to (or as a consequence of): Apply Hymile! 200-0 Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Xio Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4X Unknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 XNo Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 【XNo 2 After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours e 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aran O. Wel D23743 04/18/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive Greenbelt, MD 20770 Martin Weltz, MD 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State APR 2 0 2005

DHMH 17 Rev 1/2001

Registrar

Teresa

Brooks Arlington Joy 05-2698 AKG 1- State

98			1 - State of Ma		artment of Health a rtificate of Death		iene _{99. No.} 2005 15308
	Physici		1. Decedent's Name (First, Middle, Last) Brooks Arlingto	on.	Joy	2. Date of Deat	1.7, Day 2005 Year 8:49 A M
>	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of		4c. County of Death
			30 C Street		Cumberland		Allegany
	Funeral Director		215-16-0057 1™ 2□ F 8	e (In yrs. last birthday) 6 Yrs.	If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth (Month, Day, 12/25/19)	Year) 9. Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryl	ō	MD Allegany		Cumberland		1 ☐ Yes 2 ☒ No
	r 28e	Director	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Country?
	th wit		30 C. Street		21502		USA
36	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Madical Examirar maal be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 1 Yes 2 1 Yes, Give Year or Dates:	10	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☒ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	ture!	edp	15. Decedent's Education	16a, Dece	dent's Usual Occupation		16b. Kind of Business/Industry
15	nin 72 n "ne Medik	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done during most DO NOT use retired)	of working	Tab. Kind of Business industry
212	73 75	Ĕ	6		perating Engineer		Construction
ng	be filed ntal Hygie of other event,	Be	17. Father's Name (First, Middle, Last)			r's Name (First, Middle, A	
Maryland		ပ္		. Jo	*		Miller
Nar	12 sho h and is mu		19a. Informant's Name/Relationship (Type, Print)		-		City or Town, State, Zip Code)
	s 1 and 2 should if Health and Mer Item 27 is marke other treumatic		Margaret A. Kamauff / daughter 20a. Method of Disposition	The same of the sa	W. Main Street, I		y Tand 21332 20c. Location - City or Town, State
Baltimore,	0 0		1 N Burial 2 Cremation 3 Removal from State		osition (Name of matory or other place)		
I	permit. Pag Department Importent: I any injury o		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu eral Service Licensee 			04/21/2005 Adams Family	Hancock, Maryland Funeral Home, P.A.
B	permit. Departr Importe any inju		I til & C. adams		404 Decatur Str		
	Fnysician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final	10.	20		Interval Between Onset and Death
8760,	/Medical Examiner physician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated svents c.	a consequence of): a consequence of): a consequence of):	(TWO) OF	HEAD, CON-	
P.O. Box 687	t the death certificate by the attending phys ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	tuires tha n signed	by	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
Il Records,		Completed				24a. Was ar autops perform 1 X Yes 2	y prior to completion of cause of
Vital	icien: T certificat ector, pa	Be	25. Was case referred to medical examiner?			of Death (Check only one	е)
of	Phys r this ral dir	ition: To	Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Hospital: 1 Inpatie 28a. Date of Injury (Month, Day (Month, Day) (Month, Day)	y Year) 28b. Time o		28d. Describe ho	
Division	Hospitel or Attending 24 hours after death. Funerel Director: Afte tely filled in by the fune	Certification:	Could not be	ury - At home, farm, str c. (Specify)		City or Town	reet and Number or Rural Route Number, , State) ET, CATBERLAND, HD
	To the Hospitel or I within 24 hours after To the Funerel Directorpletely filled in b	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or in	h occurred at the time, date and vestigation, in my opinion, death	d place, and due to the ca h occurred at the time, da	use(s) and manner as stated. ate and place, and due to the cause(s)
)	To the within 2	Me	29b. Signature and title of cartifier .		29c. License number OCME		April 18, 2005
	nes		30. Name and address of person who completed cause of d		111 Penn	Street Balt	imore, Maryland 21201
	Sta Registi	100	31. Date filod (Month, Day, Year) APR 2 0 2005	ar's Signature	refe!		

George Edward 05-02938 RPD	unpend item#23a,27, perML,68	clindelible Ink. TEnsure All Co 943,5-27-05 TENSURE All Co Pepartment of Health and Menta	pies Are Legible. al Hygiene
		Certificate of Death	
Physician	1. Decedent's Name (First, Middle, Last)	, Mo	te of Death 3. Time of Death inth 1 28, 2005 1030 A M
/Medical	George Edward Kerr, III 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	
Examiner	5416 Quintana Street	Riverdale Park	4c. County of Death Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. (Mo	e of Birth onth, Day, Year) 9. Birthplace (State or Foreign Country)
Director	212-68-5259		il 20,1956 Washington, D.C
yland	10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
9 Man a-f sh lifted	Maryland Prince George's Riverd	ale Park	1 X Yes 2□No
vith the Ma t or 28a-f s be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
eath ves 23a		20737	U.S.A.
fitter death virtems 23 viner must	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\subseteq \text{Never Married} \) 2\(\subseteq \text{Married} \) 1 \(\subseteq \text{Yes, Give} \)	13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	ns or No- etc.) 14. Race - American Indian, Black, White, etc.
ours a current.	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 21 No Specify:	Specify: white
and 21215-0036 be filed within 72 hours after death with the Maryland hat Hyglene. d other than "neturel", or Items 23s or 28s-f show event, the Marical Examiner must be notified at Be Completed by Funeral Director	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
withir ene.	Elementary/Secondary (0-12) College (1-4or 5+)	`lite. DO NOT use retired) Printer	Private Industry
yland 212 ould be filed with Mental Hygiene arked other tha etic event, tre.			Middle, Maiden Surname)
arylan should be marked o umetic eve		Juanita G	ceen Smith
Aar 2 sho and 1s ma	n 1	Mailing Address (Street and Number or Rural Route	
ore, Marylai ses 1 and 2 should be of Health and Menti filem 27 is marked rother treumetice TO E	20a Method of Disposition 20h Place of	Highland Place, Indian Disposition (Name of Date	Head Mary 1 and 20640 20c. Location - City or Town, State
Pages Pages nent of int: If it	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	y, crematory or other place) of itan Crematory 4/30/200	
그 등은을 다	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Gasch	,
Daal permit Depar Impor any ir	rales () 1/ax	4739 Baltimore Avenue,	Hyattsville, Maryland 20781
ficate be executed ficate be executed with the principle of the principle	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Lise of the property of that initiated events resulting in death) Last Due to fir as a consequence of the property	myopathy with coronary a	Interval Between Onset and Death
P.O. Box (hat the death certi d by the attending detached for use a	d	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) the underlying cause given in Part I. 23	23d. Date of delivery Month Day Year le. Did tobacco use contribute to the cause of death?
cords, w requires the been signed should be defeted by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎇 Unknown
Division of Vital Records, to attending Physicien: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be errification: To Be Completed by			a. Was an autopsy performed? Yas 2 \square\$ No 24b. Were autopsy findings available prior to completion of cause of death?
Vital F /sicien: Th s certificate director, pag	examiner?	26. Place of Death (Chec	
Janes Hunes	- Emparion Ellerous	patient 3 DOA 4 Nursing Home 5	Residence 6 (Mother (Specify) At Scene escribe how injury occurred
- is is 500		m, street, factory, office 28f. Loi	cation (Street and Number or Rural Route Number, y or Town, State)
o the Hosp thin 24 hou o the Fune mpletely fil	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge. (Check only one)	, death occurred at the time, date and place, and due d/or investigation, in my opinion, death occurred at th	e to the cause(s) and manner as stated. ee time, date and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and tiple of pertifier	29c. License number	29d. Date signed (Month, Day, Year)
	(/ Jahenn)	O.C.M.E.	April 29, 2005
A (2)			
State Registrar	31. Date filed (Month, Day, Year) MAY 0 2 2005	hoste	
DHMH 17 Rev 1/2001			

				partment of Health and Nertificate of Death	lental Hygie	_	15310
	0		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		JOHN CONSTANTINE KOUYEAS		Month April	Day Yeer 2005	3:44 PM
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	J
			Frederick Memorial Hospital	Frederick		Frederic	k
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 579.36.8436 124 M 2 F 75 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Jan. 27,	ear) 9. Birthp Coun 1930 Ohio	lace (State or Foreign try)
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
	Manyl f sho	ь	Maryland Montgomery Wheato	n n			1⊠Yes 2□No
	the 1 28a-	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Coun	trv?
	3a or	٥	2019 Reedie Drive	20902		U.S.A.	,.
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	an Indian,
9	after or ita	Ē	1 Never Married 2 X Married 1 1 X Yes 2 □ No		Hican, etc.)	Black, White,	
<u>8</u>	ral',	d b	3 □ Widowed 4 □ Divorced If Yes, Give Korean	1 ☐ Yes 2 ☒ No Specify:		Specify: Whit	е
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or Itams 23a or 28a-f show ant, The Medical Examinational be modified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of work . DO NOT use retired)	ing 16	b. Kind of Business/Inc	lustry
72	within noe. han	mp	Elementary/Secondary (0-12) College (1-4or 5+)			17 11 D	
7	iled v Hygie ther t		17. Father's Name (First, Middle, Last)	Printer	e (First, Middle, Ma	Kelly Pres	S
and	ad of	Be c	Constantine Kouyeas	Contract of the contract of th	egios	iden Sumame)	
2	hould d Me mark matic	မ	•	iling Address (Street and Number or Rur		ity or Town State 7in	Code
S	id 2 s th an 27 is trau		The state of the s	Reedie Drive, Whe			
	Heal Heal tam			the state of the s		c. Location - City or To	
JO L	ages of the state		Manual 5 Clausting 2 Pullovat tight State		1/2005 S:	ilvor Cori	ng, Marylan
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "naturel; or Itams 23a or 28a-f show any injury or gither traumatic event, the Medical Exams or must be notified at once.	Í					ig, maryrain
Ã	Deg g m g n g o		Novem A Vacanty	22. Name and Address of Facility HINES-RINALDI FUNEH 11800 New Hampshire	RAL HOME,	INC.	MD 20004
,1760,	Cate be executed /Medical Examiner buy sician and burial-transit sthe burial-transit	i Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not estable, or cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the disease or consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of):	Cardiovascular Dis			Approximate Interval Between Onset and Death Years
P.O. Box 687	death certifica e attending ph id for use as th	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown	B□Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
	tw requires that s been signed E s should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to th 2 No 3 ☐ Prob	e cause of death?
al Records	The la ate has page 2	Completed			24a. Was an autopsy performe	d? prior to cor death?	osy findings available inpletion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		h (Check only one)		
ō	Phys this al dir	1°	1 XYes 2 No Hospital: 1 ☐ Inpatient 2 X ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time			e 6 Other (Specify)
	ing After	Certification:	1 X Natural 5 Pending (Month, Day Year) Injury	y Work?	28d. Describe how	injury occurred	
Sic	Attanding r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury - At home farm		28f Location (Strong	et and Number or Rura	l Pauta Alumbar
Division	or A after Dirac in by	ertif	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S		Houte Number,
_	To the Hospitel or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	O E	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, de	ath occurred at the time, date and place	and due to the accord	co(c) and manage as	atod
	24 h 24 h a Fur	edicai	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	To tha I within 2 To tha I complet	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, I	Day, Year)
	F ≤ F 0		I CIO. FLI	D37197		4-19-	2005
•	15		30. Name and address of person who completed cause of death (Item 23a) (Typ				
			Alan H. Rohrer, MD, 15 West 7th St		arvland ?	1701	
	∜ . Sta	te	31. Date filed (Month, Day, Year) 22. Registrar's Signature		arjaunu 2	2701	
	Regist	ar	APR 2 1 2005 Server & Gp	W. S.			

		For Stete Registrar	State of Maryla	nd / Dep		lealth and		ygiene Reg. No. 005	15311
Physici /Medic		1. Decedent's Name (First, Middle, Las	JHN.				2. Date of D Month APRIL	Day Yea	
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ith	4c. County of De	eath
	華	Shady Grove Adven			Rockvi			Montg	
Funeral Director		5. Social Security Number 6. Sec. 127-03-5912 Usual Residence of Decedent	מא פרוב	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	S. 8. Date of B. (Month, L. Aug. 1	oay, Year) 5, 1920 Ne	Birthplace (State or Foreig Country) W York
/land		10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
Man B-f sh	tor	Maryland Montgom	erv	Rockvi	11e				1 ⊠Yes 2 □ No
th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
23a		9501 Veirs Drive,			20850)		USA	
er de Items	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub-	lispanic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	lo- 14. Race - Al Black, W	merican Indian, hite, etc.
od within 72 hours aft giene. ar than "natural", or the Madical Expiri	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	Th. # # -
72 hours after death with the Maryland natural', or Items 23a or 28a-f show cipal Examinar must be notilised at	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	hite ss/Industry
S - 3	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w d)	orking		,
0 0 6	Completed		5+	Nuc1	Lear Engi				t of Energy
_ 0 @	0	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middi	le, Maiden Surname)	
id 2 should be file tith and Mental Hy 27 is markad oth traumatic evant	^L	Adolph	Kuhn			or Canas	Eliza		sher
d 2 sh h and 7 is n traun		19a. Informant's Name/Relationship (7	•	1				ber, City or Town, State	
1 and Healt am 2		Emma P. Kuhn/Wife 20a. Method of Disposition		Place of Dispo	osition (Name of		t ∦ l, l	Rockville,	
de E of		1 🖾 Burial 2 □ Cremation 3 🗆	Removal from State	cemetery, cre	matory or other pla	· 1			
Dermit. Pages 1 a Department of Hea mportant: if Itam any njury or othe		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License			Mem. Par			Rockville, neral Home	Maryland
permit. Pages 1 and 2 should be Department of Heatift and Menta Important: If Itam 27 is marked any njury or other traumatic events.		Meliane	Itali	My10	East De	er Park	Dr., Ga	ithersburg,	MD. 20877
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	,	ter the mode of dyir	ng, such as cardia	ac or respiratory	arrest,	Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	b. PNICUM	ONIA					4 04 15.
ifficate be executed g physician and as the burial-transit	cal Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. RUPTURED Due to (or as a conse		MINAC	AORTIC	- And	EURYSM.	J DAYS.
The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of o Month	delivery Day Year
w requires tha been signed should be de	by	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.		tobacco use contribute]Yes 2☑No 3□	to the cause of death? Probably 4 □Unknown
	Completed						per		
iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.1		eath Check on		
	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	f 28c. Injur Wor	y at		sidence 6 Other (S) how injury occurred	pecify)
al or Attanding s after death. al Director: Afte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
To the Hospital or / within 24 hours after To tha Funaral Dire completely filled in b	edical	one)	vsicien: To the best of my kiner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death occ	urred at the time	, date and place, and d	ue to the cause(s)
To the comp	Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
12		WI WAS.	T P. KURUV	uch, a	10 046	187		APRIL 20	, 2005.
		30. Name and address of person who c	ompleted cause of death (It	em 23a) (Type,	Print) OCKVILL	E PIKE	# 208	ROCKVILLE	ND 2085
Sta Registr		31. Date filed (Month, Day, Year) APR 2 1 2005	2. Registrar's Sig	nature	li)		/	-	,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** P M Ruth N. Lepley April 15 2005 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10910 Old Georgetown Road Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 15, 1907 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 97 Director 188-07-1113 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rai', or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 X No MD Bethesda Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10910 Old Georgetown Road 20815 United States deeth Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours efter ☐Yes 2MNo fYes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White à 3 X Widowed 4 ☐ Divorced Year or Dates: "natural" Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 is marked other treumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi Be permit. Pages 1 and 2 should be Department of Health and Mental Important: It tem 27 is marked any injury or other treumatic events. Robert Notestine Prudence Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Pappas/ Daughter 9626 Duffer Way, Montgomery Village, MD 20886 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Arlington National Cemetery May 005 Arlington, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicenses 22. Name and Address of Facility DeVol Funeral HOme, 10 East Deer Park Drive, Gaithersburg, MD 20877 IRACU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myelo Proliferative Disorder 2 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the deeth certificate be executed trar physician ar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical ası IF FEMALE use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year 5 Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown ģ signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan has C page 2**X** No certificate 1 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Group 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Certification: Hospitei or Attending 1 XNatural 5 Pending Injury 1 Yes 2 No death 2 Accident investigation within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Vegeph M. Haggerty mi D32407 April 20, 2005 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D., 9707 Medical Center Drive, Rockville, MD 20854 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:30A L65/20 TANK 7.2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 4415530166 SPECIALTY HUSPITAL GEURSES 641345 SPELLMAN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 22, 1913 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1□ M 2√2 F 579-09-6434 92 **Director** Poland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examiner must be notilied at 1 ☐ Yes 2 No Maryland Prince George's Adelphi Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1800 Metzerott Road, #501 20783 United States death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 MaNo If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 No White Completed by Specify: 3 Widowed 4 Divorced "netural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit iment of Health and Mental H tent: If item 27 is marked others. Be Paul Lemichuk (unk) 2 19a, informant's Name/Relationship (Type, Print) Michael J. Lesko -son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13403 Birch Bark Ct. Fairfax, Virginia 22033 rent: If item 2. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 4/21/2005 Silver Spring, Maryland 20a. Method of Disposition importent: If it 1 Laurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 permit. 21. Signature of Funeral Service Licenset once. onald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or se a consequence of) Completed by Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit Ventricular Dependency that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. physician as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No detached Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Encephalopathy; seizure disorder 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate 2 X No 1 Yes 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient Certification: To 1 ☐ Yes 2 😿 No 2X ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No thin 24 hours after death.

the Funerel Director: A

mpletely filled in by the fu investigation death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the Vithin 2 To the Complet 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 1)0026024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY MD 20185 3001 BRIVE LESTER MILES 31. Date filed (Month, Day, Year) 32 Agistrar's Signature State APR 2005 1 Registrar

				partment of Health and Nertificate of Death	Reg.		15314
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month April	7 2005	3. Time of Death
	/Medic Examir		Rosemary Landmesser 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Aprii	4c. County of Death	1.
	Examin	er	Anne Arundel Medical Center	Annapolis		Anne Arun	
	Funeral Director		5. Social Security Number $\begin{array}{cccccccccccccccccccccccccccccccccccc$	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 26	g. Birth 5, 1942 C	place (State or Foreign intry) onnecticut
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mary -f sho	ţō	Maryland Anne Arundel Annapol	lis			1 AYes 2 No
	or 28e	irec	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	intry?
	ath wi	rai	l Milkshake Lane	21403		Jnited Sta	
36	72 hours atter death with the Maryland naturel', or items 23e or 28e-f show dical Examiner must be multified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 🗷 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 🛣 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XXNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: whi	, etc.
21215-0036	72 hours "naturel",	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	166	b. Kind of Business/In	
21	be filed within 7: stal Hygiene. id other then "n event, in Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	arig		
22	filed w Hygier other ti		17. Father's Name (First, Middle, Last)	ray technician	e (First, Middle, Mai	health ca	re
lano	should be f marked of matic eve	To Be	Joseph Swift	Marion F		sen Surrame)	
Maryland	nd 2 should lith and Men 27 is marke r treumatic	-		ling Address (Street and Number or Run ilkshake Lane Anna			o Code)
Baltimore,	iit. Pages 1 and 2 should ortment of Health and Mer intent: If item 27 is marke njury or other treumatic		1 Burial 2 ACremation 3 Hemoval from State	ematory or other place)		. Location - City or To	
alti	permit. Pages Deportment of Importent: If i any njury or once		PL. LINC	coln Crematory 4-8- 22. Name and Address of Facility Joh		entwood, l or Funera	1 Home, Inc
<u>-</u>	90 5 5 9			147 Duke of Glouces	ster St. A	nnapolis,	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	onter the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode			Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate b. End Effective Due to (or as a consequence of):	Circolis			5 years
8760,	death certificate be executed e attending physician and d for use as the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Subtantic Due to (or as a consequence of):		hisol		Zhowi
9	g phys	ledic					
P.O. Box		Physician/Medicai		☐ Other (specify)		23d. Date of delive	Year Year
		by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	he cause of death?
rds	w requires been sign should be	ed b	preuman a		1 ☐ Yes	2 ☐ No 3 ☐ Prob	pably 4 Unknown
of Vital Records,	e taw has b	Completed	V		24a. Was an autopsy performed	prior to con death?	psy findings available mpletion of cause of
/ita	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death	Check on one		
of \	S S	ဥ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatie			6 ☐Other (Specify	y)
uo.	fing 1. After fune	tion	27. Manner of Death 1	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Division	Attending or death.	Certification;	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined building, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rura	ıl Route Number,
Ö	itel or irs afte rel Dir lled in		Dulluling, etc. (opecity)		Only or TOWN, Si		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
)	To To	Σ	29b. Signature and title of certified	29c. License number	29d.	Date signed (Month,	> co (1)
			30. Name and address of person who completed cause of death (Item 23a) (Type		<u> </u>	Moust 8	000
	Sta Registr		31. Date filed (Month, Day, Year) APR 11 2005	South 1	12/1	upons r	AR S C LORA
			WLK TT TOOP	7			

			1 - For State Registrar	State	of Maryla		artment of H		nd Mental Hy	giene Reg. No.	005	15315
	Dhysisi		1. Decedent's Name (First, Midd	le, Last)					2. Date of Do Month		Year	3. Time of Death
	Physici /Medic		Betty	Je	nnett		Lepley		04	Pay	05	09:30 AM
	Examin		4a. Facility Name (If not institution	n, give street and i	number)		4b. City, Town, or	Location of	Death	4c. C	ounty of Death	1
			SACRED HEA		JATTAL		COMB			A	LLEG	
	Funeral		5. Social Security Number 167-03-3448	6. Sex 1 ☐ M 2 🗓 F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bi (Month, D 01/16/1	rth ay, Year)	_ Co	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		- 00	113.			01/16/1		Penr	nsylvania
	rland ow		10a. State 10b. County		10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	Many Feb	ţō	MD A11	egany		(Cumberland					1 ☐ Yes 2X No
	r 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	untry?
	h with	a D	12512 Bedfo	rd Road, N	.E.		215	502			USA	
	deat	Funeral	11. Marital Status	12. Was D	ecedent Ever in Forces?	U.S. 13.	Was Decedent of Hi	spanic Origi	n? (Specify Yes or N Puerto Rican, etc.)	0- 14	Race - Ame	
9	d within 72 hours after death with the Maryland Jone. r than "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at	E/	1 Never Married 2 Mar	ned 1 1 Yes	s 2 No 1	943-	1 ☐ Yes 2 ☒ No	Specify:	r delto r lloan, etc.)		Black, White pecify:	ə, etc.
21215-0036	ural',	d by	3 ♥ Widowed 4 □ Divorce	Year o	r Dates: 1	946						White
5	"nat	Completed	15. Deceder (Specify only highe	nt's Education est grade complete	d)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most o	of working	16b, Kind	of Business/I	ndustry
12	within ene. than "	E C	Elementary/Secondary (0-12)	College	9 (1-4or 5+)	1116.	Health Nu			Stat	e Gover	nment
Q	Hyge than t,		17. Father's Name (First, Middle,	Last)				18. Mother	s Name (First, Middle	, Maiden Su	ımame)	
Maryland	g & 2 & 9	To Be	William	Ε.		Gett	у	Isab	elle		Spence	
<u>lar</u>	2 a a a		19a. Informant's Name/Relation						or Rural Route Numb			
	s 1 and 2 f Health Itsm 27 i		Clinton L. Leple	y / son	20h	_			., Cumberlar	, ,		
وّ	Pages nent of thint: If Its int: If Its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		III State		osition (Name of matory or other place				tion - City or	
Baltimore,	crtmen crtant: injury		* 4 □ Donation 5 □ Other (3		Su		orial Park	1	4/22/2005 Alams Fami			, Maryland
Ba	permit. Pages Department of the Important: If its any injury or o once.		Laket C.	lella	ue/		404 Decati	ır Stre	et, Cumberla	nd, Mar		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	t only one cause o	n each line.			-				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Ce	Rebro	VASC	Ular 0	cci	dont			Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a conse	equence of):	c. 1:	0 1	dont			0
		100	Sequentially list conditions,	b	to (or as a conse	nal	Carono	AV	Hry oc	C/U 51	04	0947
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	< □	10 (01 43 4 001131	34461106 01).						
	execu n and al-tra	xar	that initiated events resulting in death) Last	c	to (or as a conse	equence of):						
8760,	ate be executed obysician and the burial-transit	call		L _d .								
9	tificat g phy as th			6-5-5								
Вох	eath certific attending pl for use as t	N/U	IF FEMALE: 23b. Was decedent pregnant		outcome of preg		Ectopic pregnancy			23	d. Date of deli	very
	deat	Physician/Med	in the past 12 months? 1 ☐ Yes 2 No		egnant at time of		Other (specify)				Month	Day Year
P.O	at the de f by the stached	Phy	9 Unknown									
	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	þ	Part II. Other significant condit	AVE		esulting in the c		en in Part I.		tobacco use		the cause of death?
0.0	w require been sig	Completed	74 - 0		, - (14100	, ,				
3ec	e law has b	ld m							24a. Was		24b. Were aut prior to c death?	topsy findings available ompletion of cause of
a				-					1□ Yes	27 No	1 ☐ Yes	2 No
Vital Records,		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 St.No	Hospital:	di	O 50/0	Othe		of Death Check on			
of	ig Physical dispersal di	-	27. Manner of Death	28a. Da	ite of Injury	ER/Outpatie		at Nurs	sing Home 5 Res			ITY)
lon	E & P di	atlo	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (M igation	fonth, Day Year)	Injury		k? Yes 2∐No	0			
Division	Attandi er death. rector: A by the fu	Iffice	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	nined 286. Pla	ace of Injury - At	home, fam, st	reet, factory, office		28f. Location	(Street and town, State)	Vu <i>mber or R</i> u	ral Route Number,
	rs afte al Dire ed in t	Certification:	4 E TOTTIOGO		ilding, etc. (Spe				City of To	wii, Statej		
	To the Hospital or Attan within 24 hours after deatl To the Funaral Director: completely filled in by the	Medical	29a. Certifier Certifyi (Check only 2 Medica	Examiner: On the	the best of my k e basis of exami anner stated.	nowledge, deat nation and/or in	h occurred at the time evestigation, in my op	ne, date and pinion, death	place, and due to the occurred at the time	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)
	withii To th	Ň	29b. Signature and title of certifi	- N N		^	29c. License				signed (Month	
ے	SIVA				/w	(1)	D54	756		APR	11 19	2005
	nas		30. Name and address of person	who completed c	ause of death (It	em 23a) (Type	B : 0		perland	, MD	215	02
	Sta Registi		31. Date filed (Month, Day, Year APR 2 0	2005	2. Registrar's Sig	nature	de	٠				
			2 47 47	-								

		•	For State Registrar	State of Marylan		irtment of F tificate of a			gierie () () 5	15316
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) RICHARD WILLIAM	LONG				2. Date of Dea Month APRIL	16, 2003	3. Time of Death 6:45A. M
	Examin		4a. Facility Name (If not institution, give s SACRED HEART HOSPI			4b. City, Town, o CUMBERL	r Location of Death AND		4c. County of De	eath
ı	Funeral Director		220-38-0497	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MARCH 2	(Year)	Birthplace (State or Foreign Country) ARYLAND
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Ba-f sl	Director	MD ALLEGAN	IX C(JMBERL A					1 TYYes 2 □ No
	with the	Dire	10e. Street and Number 718 GEPHART DRIVE	E		10f. Zip Code 21502			U.S.A.	Country?
036	72 hours after death with the Maryland natural, or items 23s or 28s-1 show deal Examinar must be notified at	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1		Vas Decedent of H i Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Canaita	merican Indian, hite, etc. WHITE
215-0036	72 hours "natural", idical Exp	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occup	ation during most of work d)	ring	16b. Kind of Busine ALLEGANY	
	filed within 72 ho Hygiene. ther than "natur int, 'is Madical	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 2		STANT DI				MANAGEMENT
Maryland 21	filed Hyg Sthe Sthe	Be Completed	17. Father's Name (First, Middle, Last)		<u> </u>				Maiden Sumame)	
Ŋ		ှင	GUY F. LONG 19a. Informant's Name/Relationship (Type)	na Printl	10h Mailin	a Address (Street	MABEL		r, City or Town, State	Zin Codel
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		MARGARET J. LONG			_	DRIVE, C			502
Baltimore,			20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ R 1. Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other place MORIAL PA	ARK 04/21,	Date /2005	20c. Location - City CUMBERL	or Town, State AND, MD
Balt	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service License	enchouse)		202 GREE	I FUNERAL ENE STREE	I, CUMBE	ERLAND, MD	21502
	/Medical Examiner is the prival-transit	ıl Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary, Jacong to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):		ig, such as cardiac			Approximate Interval Between Onset and Death
, P.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent conditions con	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of di 9 Unknown	Ideath 3 aeath 5	Dectopic pregnancy Other (specify)	en in Part I.	5.1	23d. Date of o Month	delivery Day Year to the cause of death?
Division of Vital Records,	: The law requires cate has been sig . page 2 should be	Completed b	HYPERTENSIVE ATM	ANSXLEMIC	CALDI	VASCULA	M DISGA	24a. Was a autop perfor	24b. Were prior to death	Probably 4 □Unknown autopsy findings available o completion of cause of ? ? 2 □ No
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Incepital: \$7		[O#	26. Place of Deat			
of	Physic r this corral dire	1: To	1 X Yes 2 ☐ No	lospital: 12 Inpatient 2 2 28a. Date of Injury	ER/Outpatien		4 Nursing Ho		ence 6 Other (S)	pecify)
ion	ath. ath. or: Afte	atlor	1 Natural 5 Pending investigation	(Month, Day Year)	Injury		k? Yes 2□No			
Divis	tal or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Diractor: Atter this certifica completely filled in by the funeral director, t	edical	(Check only one) 2X Medicel Examin	sicien: To the best of my kno ner: On the basis of examina and manner stated.		estigation, in my o	pinion, death occur	red at the time, o	date and place, and d	ue to the cause(s)
	To T Com	Σ	29b. Signature and title of sertifier	1 11		29c. Licens OCME	e number		29d. Date signed (Mo	
	15		30. Name and address of person who co	ompleted cause of death (Item	1 23a) (Type	Print)			APRIL 17,2	
_	ne		Wha	16. all.	LEN	V 111	Penn Stre	et Balt	timore, Ma	ryland 21201
	Sta Registi		APR 1 9 2005	3. Registrar's Signa	ture	ale .				

Box 68760, P.O. Division of Vital Records,

Maryland 21215-0036

Baltimore,

State Registrar

after death.

within 24 hours a

12

á

filled in

2: Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

ANA

3 Suicide

29a. Certifier

31. Date filed (Month, D Day, Year) 2005

Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

412/05

ROAD

RUBIO , MD 111 Penn Street Registrar's Signature

Medical

Z:24P

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2XNo

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OCME

29c. License number

COLLICION

SILVER ED, SPRING, HO

MULTIVEHICULAR

NORDECK RD SUINTERGATE

APRIL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

19, 2005

		1	For State Registrar	Plea	,				d / Dep	art		lealth and N			@ 0 0 !	5	153	818
				(Circt Middle	1 act)			-					2. Date of De		10.		3. Time o	of Death
	Physicia /Medic	ın	1. Decedent's Name Doris		afso:	n	Ma	angia	pane				Month April			ear	4:30	ам
	Examin		4a. Facility Name (II	not institution	n, give stre	et and nu	mber)			4	b. City, Town, or	Location of Death		4	4c. County of	Death		
1			Shady G	rove A	dven	tist	Nurs	sing	Ctr.		Rockvi				Mont			
	Funeral Director		5. Social Security No. 579-07-9		6. Sex 1 □ M	2 2 F	7. Age	(In yrs. la 86	ast birthday Yrs.		f Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, D Oct. 3	ay, Yea			olace (State ntry) nesota	
		ļ	Usual Residence of														10d. Inside (The Limite
	show	JO.	Maryland	10b. County	ntgoi	nerv		10c. City	, Town or L		lver Spi	ring						s 2 🔀 No
	r 28a-f	rect	10e. Street and Nur								10f. Zip Code			10g.	Citizen of Wh	at Cou	ntry?	
	h witt	<u>=</u>	10610 0	lenhav	en D	rive					20902				US	5A		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if itsm 27 is marked other than "naturel", or items 23a or 28a-f show importent: if itsm 27 is marked other than "naturel", or items 23a or 28a-f show importent: if itsm 27 is marked other than "naturel", or items 23a or 28a-f show in porter treumatic event, the Mardical Examinar must be indiffied at once.	Completed by Funeral Director	11. Marital Status 1 Never Marri 3 XWidowed		ried	. Was Dec Armed F 1 ☐ Yes If Yes, G Year or I	orces? 23 [] i ive		S. 13		s Decedent of H es, specify Cuba Yes 2☑ No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)	0-		White		
2-00	72 hou nature	ted	(Spec	15. Deceder	nt's Educa	tion completed)		16a. Dec	eder e kir	nt's Usual Occup nd of work done	ation during most of wor	king	16b	. Kind of Busi	ness/Ir	ndustry	
21215-0036	within and the than "	mple	Elementary/Seco			College 2		i+)			NOT use retired ncial Ar			U.	S. Gov	ær	ment	
2	Hygie ther int, it	ပိ	17. Father's Name	(First, Middle)	Last)							18. Mother's Nam	ne (First, Middl	1				
Maryland	fental ferring freed of the eventual fice of the ferring freed of the eventual freed of	To Be	Knute W			n							tha Me				-	
lary	2 should and his mains		19a. Informant's N									and Number or Ru Lane, N.					p Code)	
2	and ealth m 27 her ti		Marian C		./ Da	ugnice	. T	20h P			ion (Name of				. Location - C		own, State	
nore	y gootl		20a. Method of Dis 1 X Burial 2 4 □ Donation	Cremation		moval fron	n State	C	emetery, cr	ema	tory or other pla	5/5, 1 Cemeter			lingto			nia
Baltimore,	permit. P Departme Importen any injur		21. Signature of Fu							22. Fr	Name and Address ancis J O Unive	ess of Facility Collins rsity Blv	Funera	al F	Home In Ver Spi	nc rinç	J, MD	20901
			shock, or hea Immediate Cause	art failure. Lis (Final	r complicationly one	cause on	each II	ne.			the mode of dyi	ng, such as cardiac	or respiratory	arrest,			Approximately and approximately and approximately and approximately appr	etween
	Physician /Medical Examiner		disease or condition resulting in death)		(a.				mentia	<u> </u>								
	uted d ansit	Examiner	Sequentially list or if any, leading to if cause. Enter Und Cause (Disease or that initiated event	onditions, nmediate erlying r injury	┨。	Due to	o (or as	a conseq	uence of):									
,09	e be executed sician and e burial-transit	ā	resulting in death)	Last	d.	Due to	o (or as	a conseq	uence of):									
89	tificate og phys as the	ed													T			
). Box 68	ndir use	Physician/Medic	IF FEMALE: 23b. Was deceded in the past 12 1 \(\text{Pyes} 2 9 \(\text{Unknown} \)	2 months?	23		birth gnant a	of pregna 2 Feta t time of o	death 3		Ectopic pregnand Other (specify)	ey .			23d. Date Mon		very Day	Year
, P.O.	w requires that the death been signed by the atte should be detached for	by Phy	Part II. Other sign		tions cont	ributing to	death l	out not res	sulting in the	e uno	derlying cause gr	ven in Part I.			co use contri			f death?
ğ	quire an sig uld b	ed											1[_l Yes	2 🗆 No	3 LJ Pro	obably 4 ³	JOHKHOWII
Division of Vital Records,	he law re e has bee ige 2 sho	Completed											24a. Whau pe	topsy rformed	d? pi	ere au rior to d eath?	topsy finding completion of 2 No	s available cause of
a	n: T ficat or, pa	e C	25. Was case refe	erred to medic	al							26. Place of De						
Ξ	sicia cert irecto	00	examiner?			spital:] Inpat	ient 2	ER/Outpat	tient	3□ DOA O	hor	Home 5□Re		e 6 □Othe	r (Spec	cify)	
n of	ng Physiter this	on: To	27. Manner of Dea	ath 5 🗆 Pend		28a. Dat (Mr	-		28b. Time Injur	e of	28c. Inju	ury at ork?	_		injury occurre			
visio	Attendi r death. ector: A by the fu	Certification:	2 Accident 3 Suicide 4 Homicide	6 ☐ Coul	tigation d not be mined	28e. Pla	ice of It	njury - At h	nome, farm,	stre	et, factory, office]Yes 2 □No	28f. Location City or		et and Numbe State)	r or Ru	ral Route Nu	umber,
ă	To the Hospitel or Atlanding Physician: The I winin 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier	1 Cortifo	ring Phys	ician: To I	the bes	t of my kn	owledge de	aath	occurred at the	time, date and place	e. and due to t	ne caus	se(s) and mar	ner as	stated.	
	Ne Hos T 24 ho Ne Fund	Medical	(Check only one)	2 Medic	al Examin	er: On the	basis anner s	of examin:	ation and/or	rinve	estigation, in my	opinion, death occ	urred at the tim	e, date	тапо ріасе, а	ng dua	to the cause	
	To the within To the comp	Me	29b. Signature an	nd title of certif		M	0					1096			Date signed)
	V		30. Name and ad	dress of perso				death (Ite	m 23a) (Typ Secon	pe, F	Print) Avenue,	Silver S	Spring,	MD	20910			

State Registrar 31. Date filed (Month, Day, Year) 2005 Registrar's Signature

1- For State of Maryland / Department of Health and M Certificate of Death		ene g. No. 005	15319
1. Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
Physician Laura Belle Midkiff		Day Year 19, 2005	6:37 a M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	
2305 Falling Creek Road Silver Sprin	ng	Montgom	ery
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birti	nplace (State or Foreign untry)
Director 579-32-7777 11 M 251 81 Yrs. State of Decedent	Jan. 1,	1924 Pen	nsylvania
			10d. Inside City Limits
Maryland Montgomery Silver Spring			1 ☐ Yes 2 ☐ XNo
106. Street and Number	10	ng. Citizen of What Co	untry?
2305 Falling Creek Road 20904			USA
Maryland Montgomery Silver Spring Maryland Montgomery Silver Spring 10f. Zip Code 2305 Falling Creek Road 20904 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married ecity Yes or No-	14. Race - Ame	rican Indian,	
1 Never Married 2 Married 1 Yes 2 100 1 Yes 2 100 No Specify:	rican, etc.)	Black, White	
8 3 ⊈Widowed 4 □ Divorced		Specify: Wh	ite
10a. State 10b. County 10c. City, Town or Location 10c. City Code 20c. City Code	ing 1	6b. Kind of Business/	ndustry
Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Num			_
To Series 8 Licensed Practical Num To Series 5 9 17. Father's Name (First, Middle, Last) 18. Mother's Name		Medica	31
Tr. Father's Name (First, Middle, Last) 18. Mother's Name Charles D. Barkley Laura	L. Balsl		
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rure			ip Code)
		-	
20a. Method of Disposition 1 El Burial 2 Cremation 3 Removal from State 1 El Burial 2 Cremation 3 Removal from State 1 Control Control 1 Co	ate 2	Oc. Location - City or	
D	il 21 2005 Br	centwood, 1	bee fract
21. Signature of Funeral Service Licensee 22. Name and Address of Facility in Service Licensee Francis U. Collins			daryland
m aasia 500 University Blvd	l, W, Sil	Lver Spring	,MD 20901
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac cannot shock, or heart failure. List only one cause on each line.	or respiratory arres	st,	Approximate Interval Between
Immediate Cause (Final disease or condition Acute Myocardial Infarction			Onset and Death 1 Hour
/Medical resulting in death) Due to (or as a consequence of):			1 mour
Examiner Hypertension Sequentially list conditions.			Year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Type Technology Due to (or as a consequence of): Degenerative Joint Disease Due to (or as a consequence of):			
Cause (Disease or injury that initiated events resulting in death) Last Co. Degenerative Joint Disease Due to (or as a consequence of):			Year
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause			
ifficate as the physical physi			
TF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delin	/en/
in the past 12 months? Comparison Compa		Month	Day Year
1 Yes 2 No 9 Unknown 9 Unknown 5 Other (specify)			
	23e. Did toba	acco use contribute to	the cause of death?
w require should it is should i	1 🗆 Yes	s 2□No 3□Pro	bably 4 Unknown
The law requires taken as should be page 2 should be completed by Completed by Complete and the complete and	24a. Was an autopsy		opsy findings available ompletion of cause of
The lave The	performe	ed? death?	
The space of Death of Death of The space of Death of Death of The space of Death of The space of Death	(Check only one))	
S S S S S S S S S S S S S S S S S S S		ice 6 Other (Speci	fy)
25. Was case referred to medical examiner? 1	28d. Describe how	v injury occurred	
2 Accident investigation 3 Suicide 6 Could not be determined control to the determined control t	186 Lanation (Ctro	and and Muse have a D	
The state of the s	City or Town,	eet and Number or Rui State)	ai Houte Number,
29a. Certifier 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cau	(SA(S) and manner as	stated
2 Accident 3 Suicide 4 Homicide 5 Accident 5 Acc	ed at the time, date	te and place, and due t	to the cause(s)
29b. Signature and title of certifier 29c. License number	290	d. Date signed (Month,	Day, Year)
D17874		April 20,	2005
Y			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sankaram M. Nayar, M.D. 3717 38th Avenue, Cottage Ci State Registrar 31. Date filed (Month Pay Year) APR 21 2005	ty, MD 2	0722	

		-	4 101	partment of Health and Mertificate of Death	lental Hygie	_4000 [532]
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Sue Ann Mercer		Month April	20, 2005 8:07 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		н	4495 Willowtree Drive	Middletown		Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd:	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign
	Director		217-42-9985		Oct. 15,	1945 Maryland
	and *	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Aaryll f sho	5	Manual and a Francisch Made	11 - +		1 ☐ Yes 2X No
	10 tha 1	ect	Maryland Frederick Midd	lletown 10f. Zip Code	100	. Citizen of What Country?
	Mith It bu	۵	4495 Willowtree Drive	21769		United States
	death ms 2:	by Funeral Director		Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - American Indian,
ပ္	after or Ite	교	1 ☐ Never Married 2 ☑ Married ☐ 1 ☐ Yes 2 ☑ No If Yes, 2 ☑ We	1 ☐ Yes 2X No Specify:	Hican, etc.)	Black, White, etc.
8	ral',	d b	3 Widowed 4 Divorced Year or Dates:	To tes ZALINO Specily.		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or Items 23a or 28e-f show he Medical Everiting to use the notified at	Completed	(Specify only highest grade completed) (G	cedent's Usual Decupation ive kind of work done during most of work	ing 16	b. Kind of Business/Industry
12	Mithin Ne	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) ancial Analyst		IBM
2	iled v Hygie thar t nt, in		12 FIII 17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	
and	nfal }	Be c	Allen A. Hartsock	Clara Cı		
2	should nd Me mark matic	ဥ		ailing Address (Street and Number or Rum		City or Town, State, Zip Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with fha Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked othar then "natural; or Items 23a or 28e-f show amy oriqury or other traumatic event, the Medical Exercities or sat be notified at angoing.	Ì	1 1 1 1	5 Willowtree Dr., N		
Baltimore,	s 1 ar		20a. Method of Disposition 20b. Place of Di	sposition (Name of crematory or other place)	Date 20	c. Location - City or Town, State
Ë	Page lent o nt: If ry or		Xbunal 2 Cremation 3 Hemoval from State	vet Cemetery 4/23	/2005	Frederick, Maryland
alti	mit.		21. Signal ve of Funeral Service Licensee	22. Name and Address of Facility Sta		
m	8 8 E 8 8		Tourtney Stauffer	1621 Opossumtown I		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not snock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	t. Approximate Interval Between
	Physician	61	Immediate Cause (Final disease or condition ARENO CARCINOI	MA OF THE PANCE	CAS	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			7.00
	⊏xamıner		Sequentially list conditions, b.			
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	and f-tran	хап	that initiated events resulting in death) Last C Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	cal E				
687	licate phys s the		d			
Вох	leath certific attending pl	N/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7-		23d. Date of delivery
ă	death a atte d for	Cla	in the past 12 months? 1 Ves 2 VINo 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
0	the de by the tached	Physician/Med	9 Unknown 9 Unknown			
٥,	The law requires that the site has been signed by the bage 2 should be detache	by P	Part II. Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
rd	w require been sig should b				1 Yes	2 No 3 Probably 4 Unknown
Records,	e law re has be	ompleted			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä		Com			performe	ed? death? SNo 1 SYes 2 No
Vital	icien: T certificat ractor, pa	Be (25. Was case referred to medical examiner?		h (Check only one)	
of V	Physicien: this certific ral diractor,	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			ce 6 Other (Specify)
		lon:	27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju (Month, Day Year)	ry Work?	28d. Describe how	injury occurred
isio	uttendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	M 1 Yes 2 No	28f Location /Stre	et and Number or Rural Route Number.
Division	il or Attend after death Director: A	ertification;	4 Homicide determined building, etc. (Specify)	, street, factory, office	City or Town,	
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	O	29a. Certifying Physician: To the best of my knowledge, c	eath occurred at the time, date and place.	and due to the cau	se(s) and manner as stated.
	e Ho	edical	(Check only 2 Medical Examiner: On the basis of examination and/o	or investigation, in my opinion, death occur	red at the time, date	e and place, and due to the cause(s)
	vithir To th	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
			A horad a count a WD	\$51.761		4/24/05
	3		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)	e Of a see	0.1701
	0		BRIAN M. O'CONNER MA 501 W.	SEVENIA W. FR	entrick	MA CIO
		ate	31. Date filed (Month Park Year) 2 2005 32. Projector's Signature	29c. License number \$3/76/ TPE. Print) FEVENTH ST., FR.		•
	Regist	rar				

			For State Registrar	State o	f Marylar		artment of F	lealth a		ental Hyg	liene eg. No.) 5	1532) Proposition
I	Physici /Medic		1. Decedent's Name (First, Midd Mabel Violet Mc							2. Date of Dea Month PRIL	Day 15, 20	Year 05	3. Time of 0	Death M
	Examin		4a. Facility Name (If not institution Memorial Hospital	1		·	4b. City, Town, o	ND			ALLE			
	Funeral Director		5. Social Security Number 217-54-6554 Usual Residence of Decedent	6. Sex 1 □ M 2 A F	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day 22-Jun-1	913	9. Birthp Cour Mary	place (State or htry) and	Foreign
	Maryland	tor	10a. State 10b. Count Maryland Alle	egany		ty, Town or Lo	ocation					1	0d. Inside City	
	h with the	al Director	10e. Street and Number 3 Jen	kins Street			10f. Zip Code 21532-				og. Citizen of	What Cour	ntry?	
9800	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f show the Medical Exerciting Frees Le ricilited at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 🎾 Widowed 4 □ Divorce	Armed Fo trried 1 ☐ Yes If Yes Giv	2 (X No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	lispanic Orig an, Mexican Specify:	gin? (Spec , Puerto Ri	ify Yes or No-	14. Ra	ace - Americ ack, White, ify: White		
1215-0	within 72 h ane. then "netu se Medical	Completed			-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most i)	of working		16b. Kind of	Business/In-	dustry	
Maryland 21215-0036	should be filed and Mental Hygid s marked other umatic event, II	To Be Co	17. Father's Name (First, Middle James Calvin Wil	, ,		homen	naker	18. Mother		First, Middle,				
	1 and 2 shor Health and N tem 27 is ma		19a. Informant's Name/Relation Gerald McKenzie			P.O. B		and Number	r or Rural Salisb	Route Number	Pennsy	/lvania	15558	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or iteme 23a or 28e-f show any injury or other treumatic event, the Medical Exacting and Lancelliked at ODGe.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (21. Signature of Funeral Service)	(Specify)	State	anuel Me	osition (Name of matory or other place thodist Ceme 2. Name and Addre Irst Funeral	ss of Facility	у	or-2005 F		Ma	aryland	
760,	Provided and was a second of the purial-fransit of the purial-fran	icai Examiner	23a. Pany Enter the disease, on shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RENAL Due to (b. DIABE Due to (c	FAILU or as a consec TTES ME or as a consec or as a consec	RE quence of): LLITUS quence of):	ter the mode of dyin	g, such as o	cardiac or	respiratory arr	est,		Approximate Interval Betwo	een
P.O. Box 68	the death certifical y the attending phy iched for use as th	Physician/Medi	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	aldeath 3	□Ectopic pregnancy □ Other (specify)	,				ate of delive	,	ear ear
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant condit HYPERTENSION, C					en in Part I.					ne cause of de	
al Records,	i: The law re loate hes be r, page 2 sho	Completed							_	24a. Was a autops perform	med?	. Were autoprior to cordeath?	psy findings av npletion of cau	/ailable use of
Division of Vital	Attending Physicien: The law requires that the death certificate be executed rideath. sctor: Atter this certificate hes been signed by the attending physicien and by the funerel director, page 2 should be detached for use as the burial-transit.	Certification: To Be	2	Hospital: 121 28a. Date of (Montality of Montality of Mon	npatient 2 Cofficient	ER/Outpatier 28b. Time o Injury	f 28c. Injur	er: 4 □ Nur v at	rsing Home	Check onl or e 5 ☐ Reside d. Describe ho	ence 6 🗆 Ot		r)	
DIV			4 Homicide	mined 286. Place building			reet, factory, office			f. Location (Si City or Town	n, State)			ər,
	To the Hospitel or within 24 hours efter To the Funerel Discompletely filled in	Medical	(Check only 2 Medica		best of my kno asis of examina ner stated.	owledge, deat ation and/or in	vestigation, in my o	pinion, deatl	d place, an h occurred	d at the time, d	ate and place	, and due to	the cause(s)	
)	3	~	29b. Signature and title of certific	mh	las	m		64004			9d. Date sign			
	had		30. Name and address of person DR. SHIV KHANNA	1221 NATI	ONA HI	GHWAY	Print) LAVALE, MA	ARYLAN	ID 2	1502				
	Sta Registi	6	31. Date filed (Month, Da	4 T 8 2005 B	egistrar's Sign	ature /	Jegar Carl							

			1 - For State Registrer	State of Ma	aryland / Dep	artment ertificate			and M		gieńe Reg. No	000	15322
			1. Decedent's Name (First, Middle, Last,)						2. Date of Dea			3. Time of Death
	Physici /Medio Examir	cal	Arlene Jamison 4a. Facility Name (If not institution, give			4b. City, 1	Town, or	Location o		April	2]	•	5:00a ^M
	Exami		Millennium Health	and Rehal	oilitation	Glen	Bur	nie			E	Anne Arur	nde1
	Funeral		5. Social Security Number 6. Sec	x 7. Ag	e (In yrs. last birthda			If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da			place (State or Foreign
	Director		249-72-9908	M 2 🖾 F	61 Yrs.		Days	110013	1				h Carolina
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation					•		10d. Inside City Limits
	Aaryli Sho	ō											ty⊡Yes 2 □ No
	the A	rect	Maryland Anne Arun	del	Glen Bu	rn1e 10f. Zip	Code				10a Ci	tizen of What Cou	
	72 hours atter death with the Maryland natural', or Itams 23a or 28a-1 show distal Examinar must be motified at	Funeral Director	7575 E. Howard Roa	d		210						ted Stat	•
	death ms 2;	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ameri	
9	or Ita	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣	No				, Puerto F	lican, etc.)		Black, White,	
93	ral', c	i by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	MCJ No	Specify:				Specify: B1	.ack
215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Dec	edent's Usua e kind of won	l Occupa	ation furina most	of workin	a	16b. K	(ind of Business/Ir	dustry
21	within ene. than "	ldm	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT us	e retired)					
121	tiled withi Hygiene. other than		12 17. Father's Name (First, Middle, Last)	2	Sea	mstres	S	10 Matha	de Name	(First, Middle,		ivate	
Maryland	d tal	Be	Raliegh Jamison								маюег	Sumame)	
Z	should nd Men marke umatic	7	19a. Informant's Name/Relationship (T)	(ne Print)	19h Ma	ling Address	(Street a		Ma1		r City	or Town, State, Zij	Code
<u>≅</u>	id 2 sho lth and 27 Is m		Arpedella Barnes/D		1								
ē	Health tam 27 other to		20a. Method of Disposition	augitei	20b. Place of Disp	osition /Nam	ne of		Di Di	9, Suit		ocation - City or To	0746 own, State
<u>o</u>	Pages nent of int: If it		1 ☐ Burial 2X☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		Metropol	ematory or ot itan C			4/26	/05	A1e	xandria,	VΔ
Baltimore,			21. Signature of Funeral Service Licens										721
ñ	permit. Departr Importe any inju		Majotti Ka	lesso	A 5	lexand 538 Ma	er S rlbo	ro Pi	e Fu ke	neral l Forest	Home vill	e. MD 2	0747
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused	the death. Do not e								Approximate
	Physician		Immediate Cause (Final disease or condition	CAAA	Claras	Da		n Y	1.0				Interval Between Onset and Death
4	/Medical		resulting in death)	Due to (or as	a consequence of):	-	u	W d	المار	cese			
н	Examiner		Sequentially list conditions	Carec	luac	Am	4/15	mia					
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):		1						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	-								
8760,	sate be executed oblysician and the burlal-transit		rosaning in dodiny 2001	Due to (or as	a consequence of):								
87	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical		d									
9 X	ding	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							22d Date of deli-	
Вох	atten for u	clan	in the past 12 months?		2 Fetal death 3	□Ectopic pre						23d. Date of delive Month	Day Year
P.O.	that the death certific ed by the attending pl detached for use as t	lsk	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknown									
	s that ned b		Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying ca	ause give	n in Part I.		23e. Did to	obacco	use contribute to t	he cause of death?
rds	w requires that s been signed t should be det	ed b	sewelia.							101	es 2	□ No 3 □ Prot	pably 4 Nnknown
S	aw re is bee	plet	Failur to	torue						24a. Was		24b. Were auto	psy findings available
m.	sician: The law s certilicate has b lirector, page 2 s	Completed by									rmed? 2√2 No	death?	mpletion of cause of 2 □ No
ita	ilan: vrtitica ctor, j	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	-43		
>	Physician: r this certitic ral director,	2	1 ☐ Yes 2 № No	fospital: 1 ☐ Inpatie				4 C Nur	rsing Hom	e 5 ☐ Resid	dence	6 □Other (Specif	y)
טַ	ing P Viter ti		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time Injury		Bc. Injury Work			8d. Describe h	now inju	ry occurred	
sio	Attending r death. ector: After y the tune	cati	2 Accident investigation 3 Suicide 6 Could not be		Amana	М		Yes 2□N					
Division of Vital Records,	or At atter of Direct in by	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. <i>(Specify)</i>	street, factory,	, office		2	Bf. Location (S City or Tox		nd Number or Rura a)	il Route Number,
	Hospital 24 hours a Funeral I	2	29a. Certifier Certifying Phy	eicien: To the best	of my knowledge, de	ath accurred	at the tim	o data and	d alasa a	ad due to the		\d	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical		ner: On the basis o and manner st	of my knowledge, dea f examination and/or ated.	investigation,	in my op	oinion, deat	th occurre	d at the time,	date and	d place, and due to	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier			29c.	. License	number			29d. Da	te signed (Month,	Day, Year)
							De	570	78	And the second of the second o	L	1-77-0	5
P	(2)		30. Name and address of person who co	ompleted cause of c	leath (Item 23a) (Type	e, Print)		- 10				1220	<u> </u>
1			ADITYA CHOPRI	Am.D. (000 Rida	elu A	ve.s	Stc.Z=	31 F	mar	201	S.MD.	21401
	Sta		31. Date filed (Month, Dey, Year)	2. Registr	ar's Signature	7			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Regist	rar	APR 2 2 2005	Done	I for	الم							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Tessie 0.30PM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis or 1 Year | If Under 24 Hrs. Home 4nne Arundel Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗐 F Hours Min. Months Days 90 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23e or 28e-1 show other treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne tarwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 100 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event. Item Elementary/Secondary (0-12) College (1-4or 5+) 20 (0 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Sumame) Be -00150 reymour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rrizt SIde 20b. Place of Disposition (Name of cometery, crematary or other p 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5- Other (Specify) of Funeral Service Licens 21 Signatore 22. Name and Address of Facility Millers Metropolitan Cha tovest Dir. AnnapalisMa Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Lower 6000 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit certificate be executed Due to (or as a consequence of): attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 28 No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Owensi D. ich aum mo 31. Date filed (Month, Day, Year) gistrar's Signature State 11 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certifi	cate of	Death	F	Reg. No	5 15001
	Physici	an	Decedent's Name (First, Middle, Last)					2. Dete of Dee Month	Day Yes	3. Time of Death
· San	/Medic	cal	Francis Xavier O' 4a Fecility Neme (If not institution, give s				4b. City, Town, or Lo		18, 2005	9 :50 PM
	Examin	ner	2512 Painter Court	·			Annapolis		Anne Ar	
	Funeral		5. Social Security Number 6. Sex			Inder 1 Year	If Under 24 Hrs.			
	Director		578-36-2647 Usuel Residence of Decedent	[M 2□F 74	Yrs. Mo	nths Days	Hours Min.	May 28	, 1930 Wa	Birthplace (State or Foreign Country) shington, DC
	ath with the Marylend 23a or 28e-f show vat be notified at	٦	10a. State 10b. County		y, Town or Location	n				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	289-f	Director	Maryland Anne Arun	idel Anna	apolis					
	E O				10	f. Zip Code			10g. Citizen of What	Country?
	a 23	eral	2512 Painter Court		S 42 Was 1	21401	liana in Ocialia (Oc		USA	mariana ladina
20	or items	y Funeral	1 ☐ Never Married 2 Married	12. Was Decedent Ever in U, Armed Forces?1 X Yes 2 ☐ No If Yes, Give	If Yes	specify Cubi	lispanic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)	Black, W	merican Indian, hite, etc.
8	ural',	Q P	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 148-1	51				W.	hite
Maryland 21215-0020	within 72 hours after death with the Marylend ene. Than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's (Give kind life. DO N	Usual Occup of work done OT use retired	during most of work	ing	16b. Kind of Busine	ss/Industry
2	77 5 6 6	S	12		Enginee	r			C&P Tele	phone
Ĕ	a de b	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Name		,	
<u>~~</u>	should be and Mentel marked o	၉	John Aloysious O'E				Maud Mar			
Ma	C1 c0 m 0		19a. Informant's Name/Relationship (Ty)						r, City or Town, State	e, Zip Code)
	s 1 and of Heelth Item 27 other tr	- 1	Mary Ellen O'Brien/ 20a. Method of Disposition	20b. P	lace of Disposition	(Name of	1	Date	MD 21401 20c. Location - City	or Town State
Baltimore,	Pages nant of nt: if lte nry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, cremator Ar Ling	y or other plac ton	ce)	51		
Ħ	permit. Pages Department of Important: If I any Injury or ance.	-	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funesal S → License		ional Cĕ		ss of Facility Rob	0/19/03	Arlin ton Evans Fun	, Virginia
B	Dep any		164							
	41		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death			-		e, MD 207	Approximate
	Physician		shock, or heart failure. List only on	e cause on each line.		,	9,	,		Interval Between Onset and Death
- d	/Medical		Immediate Ceuse (Final disease or condition		Ion	q Co	incer			14 mos.
	Examiner		resulting in death) a	Due to (or	r as a consequenc	e of):				
	p #	iner	_ b							
	ifficete be executed g physician and es tha burial-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequenc	e of):		-		
68760,	e be rsicial	edicai	that initiated events	Due to /or	as a consequence	of):				
	5 0 0	Medi	resulting in death) Lest		as a consequence	9 OI).				
Вох	ath ce ttandii or use	Physician/M	d			AA				
_ O	the a	ysic	Part II. Other significent conditions con-	tributing to death but not resu	ulting in the underly	ring cause giv	en in Part I.	23b. Did to	obacco use contribu	ute to the cause of death?
, O.	requiras that tha death cer seen signed by the attandin hould be datached for use							1 🗆 Y	es 2 No 3□	Probably 4 ☐ Unknown
rds	quiras n sigr uld be	d by						24a. Was a		b. Were autopsy findings
ပ္ပ	w requir s been s	ojet						perlor	med?	available prior to completion of cause of death?
æ	The law ete has t pega 2 s	Completed						104	65 2.2(1)c	1 ☐ Yes 2 ☐ No
ita		Bec	25. Was case referred to medical				26. Place of Death			
>	\$ w 0	2	examiner?	ospital: 1 Inpatient 2	ER/Outpatient 3[□ DOA Oth	er: 4 Nursing Hor	me 5 & Resid	ence 6 □Other (S)	pecify)
מ	ding Phys h. Aftarthis funaral d		27. Menner of Death 1 ☑Neturel 5 ☐ Pending	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y et k?	28d. Describe h	ow injury occurred	
<u>sio</u>	Attending or death. Setor: Aftai	cati	2 Accident investigation 3 Suicide 6 Could not be		N	10	Yes 2 □ No			
<u>.</u>	or Attence efter deatl Director: d in by tha	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		actory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
ш	To the Hospital or Attending Phy within 24 hours efter death. To the Funeral Director: Aftar thi completaly filled in by the funeral	20	29a. Certifier 1 Certifying Phys	 clan: To the best of my know	wledne death occur	rred at the tin	ne date and place	and due to the -	alleafe) and mann-	as stated
	Hou 124 h Fun letaly	edical	(Check only one) 2 Medical Examin	er: On the basis of examinat and menner stated.	ion end/or investig	ation, in my o	pinion, death occurre	ed at the time, d	late and place, and d	ue to the cause(s)
_	To the within To the Comple	Me.	29b. Signature and title of certifier	:0 ·· -		29c. Licens	e number	2	29d. Date signed (Mo	onth, Day, Yeer)
			> 7. Lelou	majuo		DIG	1838		4/19/2	005
		f	30. Name end eddress of person who cor	mpleted cause of death (Item	23e) (Type, Print)	000		1	15 11	onth, Day, Yeer) 005 10, 2140
			STUANT E COLO	ouich, mo	900	BRIT	gate 1	Hunai	polis, W	1a. L1401
			31. Date filed (Month, Day, Year)	32. Posistrar's Signat		,		, , , , ,		

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

2:00 p.

10d. Inside City Limits

Approximate Interval Between Onset and Death

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

Birthplace (State or Foreign Country)

White

Year Day 23e. Did tobacco use contribute to the cause of death? 2□No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 No 2 Accident 3 🗒 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

DS 2830

Bestagte Road #300, Annagols, NO Ziyul

State Registrar

has

certificate

this

s after death.

within 24 hours a To the Funerel C

filled in by the funeral

Be

Certification: To

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospitel or Attending Physicien:

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 5326 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death April 7, ^{Day} 2005 **Physician** Alvin Ormsby Scott 9:30 am /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Crofton Convalescent Nursing & Rehabilitation Crofton Anne Arundel 8. Date of Birth (Month, Day, Yeer) Comber 31, 1934 If Under 24 Hrs. If Under 1 Year Months Days Birthplace (State or Foreign Country)
 California 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Days Hours 1√2 M 2□ F 571-40-3455 70 Director December Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23e or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Funeral Director Maryland Anne Arundel Severn 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1858 Quebec St. 21144 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 □ No 195 If Yes, Give 1 ☐ Never Married 2 ☐ Married 1954 Baltimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify Specify: White Completed by 3 Widowed 4 □ Divorced 1956 Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Alvin Lysander Ormsby Margaret Buckley 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1858 Quebec St. Severn, MD. 21144 Steven Ormsby (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State April 8, Metropolitan Cremetory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2005 22. Name and Address of Facility Advent Funeral & Cremations Services M00982 42 Hudson St. Suite 110 Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a Physician/Medical Examiner buriel-trensit Attanding Physician: The law raquiras thet tha death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) physician Division of Vital Records, P.O. Box 68760, for usa as the Due to (or as a consequence of): this cartificate has been signed by the raid director, pega 2 should be datached in 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 □ No 3 Probably 4 Unknown 1 Yes δ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 25/10 1 ☐ Yes 2 ☐ No 1 ... Yat To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartific completaly filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. 28d. Describe how injury occurred 1 Naturel 5 ☐ Pending investigation Injury 2 No 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/2 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 35848 April 8, 2005 use of death (Item 23e) (Type, Print) 30. Name and address of p rson oward 1438 Defense Highway Suite 201 Gambrills, MD 21054 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

2005

1

		1 - For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	artment of tificate of	Health and I Death		giene) Rog. No.	005	15327
Physicia	0.0	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Death
/Medic		Judy L. Porter					04	17	05	0651 M
Examin	ner	4a. Facility Name (If not institution, give s	1 .1	-1		or Location of Death	n		unty of Death	
		5. Social Security Number 6. Sex	T HOSPIT	. last birthday)	If Under 1 Yea	Derlan	town .		1egar	lace (State or Foreign
Funeral Director			M 2XXF 59.	Yrs.	Months Days		8. Date of Bird (Month, Da 5-12-1	y, Year) 945	VA	itry)
ס		Usual Residence of Decedent						7.0		
anylar show	5	PA Somerset		ity, Town or Lo .yers.dal					1	0d. Inside City Limits 1 ☐ Yes 2XXNo
the M	ect	PA Somers et		.g & 65 acc	10f. Zip Code			10= Cities=	of What Coun	
Se or	<u>=</u>	6104 Cumberland t	liahwau		15552			USA	TOT WHAT COUN	uy:
death	Funeral Director		12. Was Decedent Ever in I	J.S. 13. V	Vas Decedent of	Hispanic Origin? (S	pecify Yes or No	- 14.	Race - Americ	
after or Ite		1 ☐ Never Married 2XX Married	Armed Forces? 1 ☐ Yes 2(X)No If Yes, Give		ryes, speciny Cu I⊡ Yes XXX No	ban, Mexican, Puert	o Hican, etc.)		Black, White,	
hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:						ecity: Whi	
n 72 n "nat	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occu kind of work done OO NOT use retir	e during most of wor	king	16b. Kind	of Business/Inc	dustry
with jiene. r thar	m o	Elementary/Secondary (0-12)	College (1-4or 5+)	LPN		,		Neine	ing Hom	10
e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)		- 2111		18. Mother's Nan	ne (First, Middle,			
Menta	Tof	Robert Dalton Mur	ray			Louis	e Fausti	ne wi	tt	
2 sho		19a. Informant's Name/Relationship (Ty) Harold F. Porter,		19b. Mailin	Grumbas (Stree	et and Number or Ru	ral Route Numbe	er, City or To	wn, State, Zip	
Pages 1 and 2 should be filed within 72 hours after death with the Maryland end fleath and Manfall bygiene. Int: If tiem 27 is marked other than "natural", or tiems 23a or 28a-f show mry or other traumatic event, It. Medical Eratic art must be notified at		20a. Method of Disposition				and Highwa	ay, Meye Date		2, PA	15552
ages nt of t: If it		1X Burial 2-Cremation 3 XR 4 Donation 5 Other (Specify)	emoval from State Zi	cemetery, cren	sition (Name of natory or other pl hmod Cox	netery 4-2				
- + 5		21. Signature of Funeral Service Licence			. Name and Addi		2003	were	wowig,	r A
permi Depar Impor any ir		1 de la		H	larvey H.	. Zeigler	Funeral	Home.	, Hyvidin	an, PA
455		23a. Partit Enter the disease, or complications shock, or heart failure. List only on	cations that caused the dea	th. Do not ente	er the mode of dy	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	,			JONSMA			UNG	Onseyand Death
/Medical Examiner		resulting in death)	Due to (or as a conse							8/ 2009
LAGITITICI	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	anence of).						
nsit	mine	cause. Enter Undertying Cause (Disease or injury	200 10 (01 03 0 00130	4401100 01).						
exection and in all tra	Examin	that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
icate be executed physician and s the burial-transit	dical									
entifica ing ph e as th	0	IF FEMALE:								
leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnan	су		23d.	Date of deliver	ry Dav Year
the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify) _					- 1,
v requires that the de been signed by the should be detached		Part II. Dther significant conditions con	tributing to death but not re	sulting in the ur	iderlying cause g	ven in Part I.	23e. Did to	bacco use o	contribute to the	e cause of death?
quires on sign	ed by						1 🗹 Y	es 2□N	o 3 🗆 Proba	ably 4 Unknown
aw requir is been si 2 should	Completed						24a. Was		4b. Were autop	sy findings available
The law cate has page 2 t	Com						autop perfor	med?	death?	npletion of cause of 2□ No
ysician: This certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea		4"		
Physic this c	2	1 165 21 110		ER/Outpatient	SLIDOA		ome 5 Resid)
ding Phy h. After thi funeral	lon:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ury at ork?]Yes 2 □ No	28d. Describe h	ow injury oc	curred	
or Attendation description of the description of the crossion	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, farm, stre			28f. Location (S	treet and No	umber or Rural	Route Number,
al or a after al Dire	Certification;	4 Homicide	building, etc. (Spec	ify)			City or Tow	m, State)		
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director. page 2 should be detached for use as		29a. Certifier 1 Certifying Phys	ician: To the best of my kn er: On the basis of examin	owledge, death	occurred at the t	ime, date and place,	and due to the o	cause(s) and	I manner as sta	ated.
the H nin 24 the F nplete	Medical	one)	and manner stated.							
D N N	2	29b. Signature and title of certifier	01/		29c. Licen	se number		Date sig	gned (Month, E	ay, Year)
6		30. Name and address of person who con	moleted cause of death (the	m 23e\ /T *	Print)			THE INT	-1.0/	70-3
nds		11 1	mpleted cause of death (Ite may 625 32 Registrar's Sign	Kont	Anoni	IP Cier	herla	nd	Md	2/500
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	call 1	, curr		1	1.00	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physicia		State of Maryland / Departme State of Maryland / Departme Part Amend Items 25,28a-f per ME, G823,05/(Certifica) 1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
/Medic		Jerry Allen Powell		April	9 2005	6:00 P M
Examin	er		y, Town, or Location of Death		4c. County of Death	
		92 Duke of Gloucester St. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	Annapolis er 1 Year If Under 24 Hrs.	a Data of Dist	Anne Arı	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11 Undt 316-36-0778 8. Was also be secured by the secure of December 1. Secure of December		8. Date of Birth (Month, Day, July 26,	1936 Inc	place (State or Foreign Intry) liana
yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Mar Med	tor	Maryland Anne Arundel Annapolis				1 AYes 2 No
death with the Maryland ms 23e or 28e-f show	Director		ip Code	10	g. Citizen of What Cou	intry?
ath wi	ral	92 Duke of Gloucester St.	21401	U	Inited Stat	es
urs after el', or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married if Yes, spi 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Neuron Dates: 1954–1963	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2CXNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amen Black, White Specify: whi	, etc.
72 ho	Completed	15. Decedent's Education 16a. Decedent's Usi (Specify only highest grade completed) (Give kind of w	ual Occupation rork done during most of work	10	6b. Kind of Business/Ir	
ithin Be.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	use retired)			
lygier her t		3 Systems 17. Father's Name (First, Middle, Last)	Program Manage		informatio	n systems
Mental F Mental F arked of atic ever	To Be	Ulysses Powell	18. Mother's Name Nedra Be		aiden Sumame)	
2 sh and is m		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) 19b. Mailing Addres	ss (Street and Number or Rura	al Route Number, (City or Town, State, Zi,	o Code)
l and lealth im 27 her ti		Pam Roblyer/ wife 92 Duke of	of Gloucester			
if its		20a. Method of Disposition 1			Oc. Location - City or T	
rtmen rtent njury		`4 ☐Donation 5 ☐Other (Specify) Crownsville Ve			rownsville	*
Depa Impo eny ir		Lest Romaned 147 Da	and Address of Facility Joh uke of Glouces	ter St.	Annapolis,	CONTRACTOR OF THE PROPERTY OF
/Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	varying/a	sphyxi.	ation	Approximate Interval Between Onset and Death
nysicia he bui	ical Ex	Due to (or as a consequence of):	CENTIFICATION APPR	OVED BY MEDICAL!	EXAMINER	
n signed by the attending phy Id be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic prognant at time of death 5 Other (specific prognant) 1 Ectopic prognant at time of death 5 Other (specific prognant) 1 Ectopic prognant 2 Ectopic prognant	pregnancy		23d. Date of delive Month	ery Day Year
p eq	by	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part I.	23e. Did toba	cco use contribute to the	he cause of death?
has je 2	Completed	•		24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
r this certific ral director,	2	1 Inpatient 2 ER/Outpatient 3 Do	OA 4 Nursing Hor	ne 5 Aesidend 28 Des ibe how	e 6 ☐Other (Specif	y)
r death. ector: After by the fune	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 04/09/2005 Unk PM			nanged self	
octor	lica	3 Special 6 Could not be 28e Place of Injury - At home farm street factor		28f. Location (Stree	et and Number or Rura	Il Route Number
d in t	Certification:	building, etc. (Specify) At home		92 Duke o	et and Number or Rura State) Annapoli of Glouches	ster.
	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation and manner stated.	at the time, date and place, a	nd due to the caus	so/s) and manner as si	tatad
withi To the	Σ	Marins t- Hotte mo	c. License number	29d	Date signed (Month,	Day, Year)
	١.	30. Nama and address of person who comple edicause of death (Item 23a) (Type, Print)	TIDEWATER (wanu r	AN NA	out, mp

			1 - For State Registrar	State of	Marylar	•	artment rtificate			nd Me	ental Hyg	jiene leg. No.	2005)	15329
I	Physici /Medio		1. Decedent's Name (First, Middle, t Bernetta P.	Richards							2. Date of Dea Month April	Day 13	200	5	3. Time of Death 4:34 P
	Examir Funeral Director	er	4a. Facility Name (If not institution, g Washington A 5. Social Security Number 6. 578–12–6075	dventist	Hospit 7. Age (In yrs.		Т	akon	Location of 18. Par If Under 2 Hours	k 24 Hrs. Min.	8. Date of Birth (Month, Day Sep. 10	Year)		gom Birthpla Country	ery ce (State or Foreign h. DC
	D	tor	Usual Residence of Decedent 10a. State 10b. County DC			ty, Town or Lo	ocation		Washi				71		I. Inside City Limits 1 Xes 2 No
336	be filed within 72 hours after death with the Maryland tial Hygliene. ad other than "natural", or items 23a or 28a-f show event, the Medical Exacultational to incitilise an	by Funeral Director	10e. Street and Number 502 L St., N. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For	ces? 277 No e		Was Deced If Yes, spec	20 ent of Hi rfy Cuba	002-3 spanic Orig n, Mexican Specify:		city Yes or No- lican, etc.)		uen of What United 4. Race - Al Black, W Specify:	St	ates Indian, c.
Maryland 21215-0036	filed within 72 hou Hygiene. Ather than "nature int, the Mudical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 12th	grade completed) College (1-	-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Ex	k done d	luring most)	of workin	g	16b. Kir	Gov		ment
aryland	2 should be file and Mental Hy is marked oth sumatic event	To Be (17. Father's Name (<i>First, Middle, La</i> Joseph 19a. Informant's Name/Relationship	C. Parke	er	19b. Maili	ng Address	(Street a			(First, Middle, Mary Route Numbe	Ε.	Cook	, Zip C	ode)
	of Health of Health litem 27 r other tr		Canardo M. Ric 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from S	20b. F	Place of Dispo cemetery, crea	osition (Nam matory or ot	e of her place	a)	Da	h., DC	20c. Loc	cation - City	or Town	
Baltimore,	permit. Page Department: Important: fl any Injury o		4 □ Donation 5 □ Other (Spe 21. Signature of Fineral Service Lic	Terra	\$ TI		2. Name and 4001	Addres Ben	s of Facility	St.	ewart F	uner ash	_	me	
	Priysician /Medical Examiner		23a. Part Jenter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or o ndition resulting in death) Sequentially list conditions,	a	ach line. Cabolic or as a conseq Acute R	Acido	sis		g, such as o	cardiac or	respiratory arr	est,		lr.	pproximate titerval Between Inset and Death 1Week
8760,	ate be executed hysician and the burial-transit	lical Examine	Sequentially list conditions, if any, leading to immediate date. Exact Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	or as a conseq or as a conseq										
O. Box 6	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		inth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pre					2	3d. Date of o	lelivery D	ay Year
ords, P	w requires that been signed t should be det	b	Part II. Other significant conditions Chronic Ro	enal Fail	ure, H	ypothy	roid					baccous es 25			cause of death?
Vital Records,		O	Chronic Renal Failure, Hypothyroid Congestive Heart Failure, Non-insulin dependent diabetes 25. Was case referred to medical 26. Place of Death (congestive)								24a. Was a autop: perfor 1 Yes	med? 2 XNo	24b. Were prior t death 1 🗌 Y	o comp	y findings available letion of cause of
of	Physicia this cerral direct	examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other								sing Hom	e 5 Resid	ence 6		oecify)	
Division	vital or Attending urs after death. raf Director: After lled in by the fune	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an								2	8f. Location (S City or Tow	n, State)			
	To the Hospital of within 24 hours af To the Funeral Completely filled in	Medical	(Check only 2 Medical Ex	Physician: To the saminer: On the ba and mann	isis of examina	owledge, deat ation and/or in	vestigation,	in my op	e, date and pinion, deat	d place, at h occurre	d at the time, o	ate and	and manner place, and d signed (Mo	ue to th	le cause(s)
	5 7 × 10		▶ Utille	MD					D6100	7			120,		
K	(5)		30. Name and address of person where Kenneth Khamatan San Date filed (Month, Day, Year)	andagle,	M.D. 8	31 Eas	t Uni	vers	ity B	lvd.	, #25 S	ilve	r Spr	ing	MD 20903
	Sta Registi		APR 2 2 20	105	egistrar's Signa	S Sport	No.								

			For State Registrar	State of Ma	aryland	-	irtment of H tificate of I		-	1		12330
			Registrar 1. Decedent's Name (First, Middle, L	ast)		061	incate of t	Jeani	2. Date of De	Reg. No. U	J U	3. Time of Death
	Physici		MA	,	. S	AUNDI	ERS		APRIL	14,20	Year 0.5	3:10A M
	/Medic Examin		4a. Facility Name (If not institution, g		, D ₂	. 101101		Location of Death		4c. Count		10.1011
			Shady Grove	Adventist	Hos	g	Rocky	ville		MON'	TGOM:	ERY
	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Apr 9	th 19. 193 7/1 =	Cour	place (State or Foreign
	Director		577-64-8963 Usual Residence of Decedent	70 111 224	60	Yrs.			Apr 9	, 1943	D.C	•
	land ow	İ	10a. State 10b. County		10c. City,	Town or Lo	cation				1	Od. Inside City Limits
	Man,	tor	MD MOnt	goemry]	Rocky	ville					1¥EYes 2□No
	iter death with the Marylan I tems 23a or 28a-f show Uner mat be mailfied at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	ath wi	rai	735 Elmcroft					0850			S.A.	
	after dea or Items	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of H f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)		ce - Americ ck, White,	
36	within 72 hours after death with the Maryland ane. than "neturet", or liems 23a or 28a-f show Ita Madigal Exiz. direct inset by codiffied at	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 22 1 If Yes, Give Year or Dates:	NO	1	☐Yes 2☐No	Specify:		Specia	y: B	lack
21215-0036	2 hou	ted	15. Decedent's	Education		16a. Deced	lent's Usual Occupa	ation	leina	16b. Kind of B	lusiness/In	dustry
218	thin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5		life. L	OO NOT use retired)	Kiriy		sing	
21	ygien ygien her th	Cor	12th	-41		Home	Health	n Aide 18. Mother's Nan	- (5) 10	Enter		e
Maryland	htal Hedotled ot	Be	17. Father's Name (First, Middle, Last Bennie Gile						leen T		,	
Ĕ	hould d Mer mark metic	ဥ	Bennie Gile 19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a					Code)
Z	ulth ar 27 is r treu		Marilyn Wood-				Elmcro					850
re,	item item	977	20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of natory or other place	e)	Date	20c. Location	- City or To	own, State
m	Page nent c ant: If		1 ☐Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Special)		Gat	e øf	Heaven	4/2				ring,MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "neturef, or any injury or other treumetic event. If a Madical Examona.	1	21. Signal Lie of Funeral Service Lic	ensee)	. (. Name and Addres					
Ш	207 29		- COUP	T) XIVILLE	elx		46 N. Wa				TTE,	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	4 .			g, such as cardiad	or respiratory a	rrest,		Approximate Interval 8etween Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		Ocer	dul	defert	~			7 hr
	Examiner		1	Due to (or as	a conseque	nce of):		C				
		ler	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying	b. Due to (or as	а волвации	nes of):						
	cuted	Examin	that initiated events	с								
Ö,	e exec ian ar urial-t		resulting in death) Last	Due to (or as	a conseque	nce of):						
68760,	icate be executed physician and s the burial-transit	dical		d								
			IF FEMALE:	23c. If yes, outcome	of pregnanc	'n				004 D		
Вох	death certifii e attending p ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			1	ite of delive onth	Day Year
o	0 0	ysi	1 Yes 2 No 9 Unknown	9□ Unknown			,					
s, P	The law requires that the ate has been signed by the bage 2 should be detache	by PI	Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to th	ne cause of death?
rds	quire an sig uld b								1 🗆 '	Yes 2□No	3 Prob	ably 4 Unknown
Record	law requas been 2 should	piet							24a. Was	an 24b.	Were auto	psy findings available npletion of cause of
<u>ac</u>		Completed							perfo	rmed?	death? 1 ☐ Yes	3 June
Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examinar?	Manaital		/	0,4	26. Place of Dea				
of	Physic this o	7	1 res 2 No 27. Manner of Death	Hospital: 1 Inpatie		VOutpatien 8b. Time of		^{er:} 4 ☐ Nursing H		dence 6 Oth		/)
	ding h. After funer	tion	1 Datural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	28c. Injun Work	Yes 2□No	200. Describe	now injury occur	100	
Division	Attending er death.	fica	3 Suicide 6 Could not	be 28e. Place of Inj		e, farm, str	eet, factory, office		28f. Location (Street and Numi	ber or Rura	I Route Number,
ā	el or Att	Certification:	4 Homicide	building, et	c. (Specify)				City or To	wn, State)		
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in D	edical (29a. Certifier 1 Certifying 1 (Check only one)	hysician: To the best aminer: On the basis o and manner st	f examinatio	edge, death n and/or inv	occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner as si and due to	ated. the cause(s)
	o the o the omple	Mec	29b. Signature and title of confiler	and manner St	w.04.		29c. License	number		29d. Date signs	d (Month,	Day, Year)
)	⊢ <i>s</i> ⊢ ŏ		> Sug	gum of			2009	57455		April	14	2005
	8		30. Name and address of person wh									_
			Sunil Saxena					Dr Rock	ville,	MD 20	850	
	Sta		31. Date filed (Month, Day, Year) APR 2 1	2005 32. egistr	rar's Signatur	le la	all					
	Registi	ar	WLL TI	Blow	10	Pal						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Fedora Stokes April Links 2005 ar 18, 10:49A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 5, 1906 Birthplace (State or Foreign Country) **Funeral** Days 212-64-0524 1 ☐ M 2 💢 F Hours 98 Yrs. Director Louisíana Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Exercities and be nedified at 10d. Inside City Limits Maryland Frederick Director Frederick 1 Tyes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Rosemont Avenue 21701 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: δ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker own home parmit. Pages 1 and 2 should ba filed Department of Health and Mental Hygis Important: If itam 27 Is marked othar any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Links Antionette Daure ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Okan –daughter 613 Rosemont Avenue Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State Metropolitan Crematory 4/19/2005 Alexandria, Virginia `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licepsee Bonard Funeral Home, P.A 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a suse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure 1 month /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Physician/Medical as the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ signed by details Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hypertension 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2☑No cartificate 1 Yes 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 18, 2005 009189 lurre 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, MD 300 West 9th Street Frederick, Maryland 21701 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended #26 per MD; FCHD Tm Certificate of Death 04/22/2005 Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOHN RECKORD SLAGLE April 19, 2005 11:54 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 217-10-9253 Director 86 July 21, 1918 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23a or 28e-f show it is sermost be notified at 1KYes 2 No Directo Frederick Maryland Frederick 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 750 Carroll Parkway 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced White "naturel" er than "natur. I've Medical I Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) City Auto Elementary/Secondary (0-12) College (1-4or 5+) Owner & Operator Radiator Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked George Cornelius Slagle, Sr. Margaret Gertrude Blumenauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trea Margaret Van Fossen (Sister) 212 Wyngate Drive, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 4/22/05 Frederick, Maryland 22 Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P 21. Signature of Funeral Service Lig 1201 NORTH MARKET SI., FREDERICK, MD 21701 23a, Part1. Enter th Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** ardiovascular /Medical Examiner pertension Ear Sequentially list conditions, if any, leading to infine lists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (g) as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗆 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has l autopsy page certificate 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ → 6 □Other (Specify) this After this funeral o Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. escribe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medic 29b. Signature and title of certifier X, 30. Name and address of person who completed cause death (Item 23a) (Type, Print) St. Frederick, MD 21701 31. Date filed (Month Da)

Registrar DHMH 17 Rev 1/2001

State

sistrar's Signature

2005

			Please	State of Maryla						Die.		
			1 - For State Registrar	State of Maryta		rtificate of L			eg. No.	05	153	133
	g ·		Decedent's Name (First, Middle, La	st)			,	2. Date of Deat	h		3. Time of	Death
	Physici /Medic		June Marie Sosebe	ee				April 1	.9, 200.	Year 5	8:45	AM
	Examin		4a. Facility Name (If not institution, giv	re street and number)			Location of Death		4c. County			
			10701 N. Lansdale		a la sé bisébula si	Glenn Da	ale If Under 24 Hrs.	9 Date of Righ	Prince			. Caraina
	Funeral Director		5. Social Security Number 6. 5	7. Age (in yr	s. <i>last birthday)</i> Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 01/09/1	Year) 926	Coun	lace (State or try) nois	Foreign
			Usual Residence of Decedent					02/07/2				
	show	٠,	10a. State 10b. County		City, Town or Lo					1	0d. Inside Cit 1√∑Yes	
	ith the Marylan or 28e-f show	ecto	Maryland Prince (Georges Gl	Lenn Da	Le 10f. Zip Code		1	0g. Citizen of V	What Cour		
	with the or 3	Funeral Director	10701 N. Lansdale	Street		20769			USA	mat oour		
	death ms 23	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Rac	e - Americ		
ဖွ	or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		ir res, specily Cuba 1 □ Yes 2 🔯 No	Specify:	rican, etc.)	Specify	ck, White,	etc.	
215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28e-1 show he Medical Evanirer must be notified at	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	100 Dans				16b. Kind of B	Whi		
45	in 72 i "net	olete	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of work		_	ernme	•	
212	filed withi Hygiene. other than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Law 1	Librarian			Account	ting	Office	
bu	be filed tal Hygi d other avant, t	BeC	17. Father's Name (First, Middle, Last	')			18. Mother's Name	e (First, Middle, I	Maiden Suman	10)		
<u>ya</u>	2 should be fi and Mental H 18 marked ot raumatic avar	2	Arthur Wasem				Martha L					
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. ortant: If itam 27 is marked other than "netural", or items 23e or 28e-1 show injury or other traumatic event, it a Medical Evantret must be retilised at injury or other traumatic event, it a Medical Evantret must be retilised at 8.		19a. Informant's Name/Relationship			Clon Arror					Code)	
	of Health of Health litam 27 I		Jeffery A. Sosebe		. Place of Disp	Glen Aver	! !	and the second second	20c. Location -		wn, State	
ion I	ages ant of at: If it		1 ☐Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Con		cemetery cre Mary terans	matory of other place land Cemetery	04/2	6/2005 c	heltenl	am.	MD	
Baltimore,	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Lice			2. Name and Addres						e
ä	Depar Impor eny ir		hollet	_		16000 Anna				0715		
	Physician		23a. Part1. Enter the disease or conshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the devone cause on each line.	eath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Bety Onset and D	veen
	/Medical Examiner	П	resulting in death)	Due to (or as a cons	equence of):			A)	
		ē	Sequentially list conditions,	b. Due to [or as a cons	equence of					- 19		
	cuted id	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
60,	e be executed rsician and e burial-transit		resulting in death) Last	Due to (or as a cons	equence of):							
6876	cate b chysic the b	dical		d								
9 X	leath certificate i attending physi I for use as the l	/Me	IF FEMALE:	23c. If yes, outcome of preg					23d. Da	te of delive	erv	
O. Box	0 0 0	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		 		nth	,	'ear
P.0	The law requires that the de te has been signed by the age 2 should be detached		Part II. Other significant conditions	contributing to death but not r	esulting in the	inderlying cause give	en in Part I.	23e. Did tot	pacco use cont	ribute to th	ne cause of de	eath?
rds	quires n sigr uld be	ed by						1 □ Ye	es XNo	3 🗌 Prob	ably 4 □U	Inknown
000	aw requir ts been si 2 should	plet						24a. Was a	n 24b.	Were auto	psy findings a npletion of ca	vailable
I Re		Completed						perfor	ned2	death? 1 🔲 Yes		
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Cth	26. Place of Deat					
of	Phys rthis raldi	. To	1 ☐ Yes Se No 27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Injun	er: 4 Nursing Ho	ome 5 Residence 28d. Describe ho			1)	
on	Afte fune	tion	Natural 5 Pending	(Month, Day Year,) Injury	Wor	k? Yes 2 □ No					
Division of Vital Records,	Attandi	Certification;	3 Suicide 6 Could not determined		t home, farm, si	reet, factory, office		28f. Location (St City or Town		er or Rura	l Route Numb	20 <i>r</i> ,
	ital or rs afte ral Dir led in	Cert		1								
	To the Hospital or Attanowithin 24 hours after death To tha Funaral Director: completely filled in by the	edical		hysician: To the best of my laminer: On the basis of exam and manner stated.						and due to	the cause(s)	
	To the within 2 To tha comple	Σ	29b. Signature and title of certifie	all A		29c. Licens	1760S	2	9d. Date signe	d Month,	Day, Year)	
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type	, Print)	A-n n		V V Y	-		
			D.J.	ALDAK ,	am	CHY	MON 1	ND				
**		ate	31. Date filed (Month, Day, Year)	32. Fagistrar's Sig	gnature	6.4.	V					
19	Regist	rar	APR 20	2005 Reserve	15° A							

1. Decements Name (Frast, Middle, Last) Physician (Middle) Physici		ļ	For	State of Marylar	nd / Depa		t of H	ealth and N	Mental Hyg	iene	E 1500
Physician (Medical Exampson 1			Registrar	aet)		incate	OI L	Jean			3. Time of Deat
## Februshment of Markhambers, give shreet and number ## April	Physici	an							Month	Day Y	ear
Second Security Number Second Security Num						41. 05.	T	1			
Social Security Number Social Security Number Control Contr	Examir	ner		ive street and number)		4b. City,	lown, or	Location of Death		4c. County of	Death
S77—20-9710 10 20 F 86 vs. Months Days Rouse Mn Aug. 4, 1918 Washington Wash				Carry 7 Ann /la um	last hirthday				Q Data of Right		
Does the features of December 100. Color			·						(Month, Day	Year)	Country)
The first and properties of the control of the cont	Director				113.				Aug. 4,	1918 W	asnington, I
Beamertary/Secondary (0-12) College (1-4or 5+) Teacher Tea	and			10c. Ci	ty, Town or Lo	cation					10d. Inside City Lin
Beamertary/Secondary (0-12) College (1-4or 5+) Teacher Tea	Aaryl sho	ō	MD Anno	Arundol			241	77			1 □ Yes 2√2
Beamertary/Secondary (0-12) College (1-4or 5+) Teacher Tea	the N	ect		AL UTICE!		104 7in		IIersvil		Do Citizon of Wh	at Country?
Beamertary/Secondary (0-12) College (1-4or 5+) Teacher Tea	with a	ā		-1		101. 210		100	'		
Beamertary/Secondary (0-12) College (1-4or 5+) Teacher Tea	s 23	ra			10 40	M D					
Beneartary/Secondary (0-12) College (1-4or 5+) We Do Not I use ariserial District Of College (1-4or 5+) We Do Not I use ariserial District Of College (1-4or 5+) Teacher District Of College (1-4or 5+) Teacher Name (First, Middle, Molitice, Molitic	er de Item	nue		Armed Forces?	1.5.	was Deced f Yes, spec	ent of Hi	n, Mexican, Puerto	Rican, etc.)		
Beneartary/Secondary (0-12) College (1-4or 5+) We Do Not I use ariserial District Of College (1-4or 5+) We Do Not I use ariserial District Of College (1-4or 5+) Teacher District Of College (1-4or 5+) Teacher Name (First, Middle, Molitice, Molitic	s aft	Ϋ́		If Yes, Give		1□Yes 2	ZZ No	Specify.		Specify:	White
Bernerlary/Secondary (0.12) College (1.4or 5+) Wife DO Not Interview District Of College (1.4or 5+) Wife DO Not Interview District Of College (1.4or 5+) Wife DO Not Interview District Of College (1.4or 5+) District Of College (1.4or 5+) Wife DO Not Interview District Of College (1.4or 5+) District Of Coll	urel E	d b			10- D	d 44 - 14		a di a un		10) Kind of Busin	
Physician Medical Examiner 23a Part i. Enter the disease, or complications that cause of each line. Impediate Cause of respiratory arrest. Park in the mode of drying, such as cardac or respiratory arrest. Appropriate Teaching in death) 25a Part i. Enter the disease, or complications that cause of each line. Impediate Cause of respiratory arrest. Appropriate Teaching in death) 25a Part i. Enter the disease, or complications that cause of each line. Impediate Cause of respiratory arrest. Appropriate Teaching in death) 25a Part i. Enter the disease, or complications that cause of each line. Impediate Cause of each line. Impediate Cause of the University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the mediate leaves. Either University of the leaves of the part of the leaves of the part of the leaves of the part of the leaves of the part of the leaves of the part of the leaves of the leav	"ned	lete	(Specify only highest g	rade completed)	(Give	kind of wor	rk done a	turing most of work	king		•
23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximately the disease, or complications that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximately the disease, or complications that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximately the disease, or complications that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximately the disease, or complications that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximately the disease, or complications that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of drying such as cardac or respiratory arrest. Bould to the cause of the drying and the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Bould to the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Bould to the part of the drying and the deeth. Do not enter the mode of the drying arrest. Bould to the part of drying arrest.	Mithir han	mp	Elementary/Secondary (0-12)		mo.						
23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximate the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximate the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximate the mode of dying, such as cardac or respiratory arrest. Approximate the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximation that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Bould the mode that the caused of the cause o	fygie her t		17 Fatharia Nama (First Middle La		1				o /First Middle		7
23a Part Einet the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximately the control of the part a live - list only one cause on each line. Due to (or as a consequence of): Due to (or as a consequ	tal Find of	Be		·							
28. Part Ether the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximately the cause of the control of the cause of the c	Men Men arke	To									
28. Part Ether the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximately the cause of the control of the cause of the c	and and ls m					•					
23a Part Lefter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation Course (Part Indiana List only one causes on each line. Approximation Course (Part Indiana List only one causes on each line. Due to (or as a consequence of): Due to (or as a consequence o	and ealth n 27 ner tr		Marilynn S. Fie		_177			circle,	_		
23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of drying, such as cardac or respiratory arrest. Approximately the control of the second of	of He	1	•		Place of Dispo cemetery, crei	sition (Narr natory or ol	ne of ther plac	e) Ann		20c. Location - Cit	ty or Town, State
23a. Part Liefe the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximately the control of the part failure and such as a consequence of): Due to (or as a consequen	Pag nent nnt: I				tro Cr	emato	ry	Whr.	2005	Baltimo	re, MD
23a Part Lifet the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximately the control of the disease of seed in the mode of dying, such as cardiac or respiratory arrest. Approximately the control of the disease of seed in the mode of dying, such as cardiac or respiratory arrest. Approximately the control of the disease of seed in the mode of dying, such as cardiac or respiratory arrest. Approximately the control of	mit.		21. Signature of Funeral Service Lic	9500/	22	. Name an	d Addres	s of Facility		Dl-	There 1 17
23a Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interestal shows or heart failure. List only one cause on each line. When the state of the cause o	8858		1 thouse	LU .	4	95 GO	V. k	itchie H	wv. Seve	rna Park	MD 21146
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	100		23a. Part1. Enter the disease, or co	mplications that caused the dee							Approximate Interval Between
Per per per per per per per per per per p	Dhysisian		Immediate Cause (Final	y one cause on each line.	. 1	1.	m	ation			Onset and Death
Sequentially list conditions, it also passed to finior the past 12 programs of				a. Advan	00	-au	MIU	411164			- gear
FFEMALE: 23b. Was decedent pregnant in the past 12 might 12 might 2				Due to (or as a consec	(derice of).						V
Section Company Comp		<u></u>	Sequentially list conditions,	b. — Due to (or as a consec	uence of):						
FFEMALE 236. Was decedent program 23c. If yes, outcome of pregnancy 1 Live birth 2 Felat death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Month D	nsit lec	Ē	Cause (Disease or injury								
IFFEMALE 23b. Was decident prognant 23c. If yes, outcome of pregnancy 1 1 1 1 1 1 1 1 1	and and II-trai	xar	that initiated events	c. Due to (or as a consec	uence of):						
IFFEMALE: 23d. Date of delivery 23d. Date of del	ician	alE									
25. Was case referred to medical examiner? 1	phys the			d.							
25. Was case referred to medical examiner: 1 Yes 2 No	ding	/Me		23c. If was outcome of pregn	ancu						
25. Was case referred to medical examiner? 1 Yes 2 No	or us	jan	in the past 12 mooths?	1 ☐ Live birth 2 ☐ Feta	al death 3						,
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manny of Death Mospital: Impatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) V 27. Manny of Death 1 Metural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury 28h. Time of Injury 28	the a	sic	1 ☐ Yes 2 ŪNo		leath 5L	Other (spe	ecity)				
25. Was case referred to medical examiner to completion of death? 27. Manny of Death 1	d by etach	Phy			. M			. C. D. Al	OO- Did to		A- A- Ab
25. Was case referred to medical examiner? Yes 2 No	p ed		0 1 11	contributing to death but not res	suiting in the u	nderlying ca	ause give	an in Part I.			
25. Was case referred to medical examiner? Yes 2 No	en s bluo	ted	03/2001/1/11	1115					1 U Y	s 2∐No 3[Probably 4 Donkno
25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Mann of Death 1 Notatural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time s be 2 sh	pie								n 24b. We	re autopsy findings availa	
25. Was case referred to medical examiner? Tyes 2 No	age	E							perform	ned? dea	ith?
27. Manny of Death 1 Work? 27. Accident 3 Suicide 4 Homicide 1 Destributing 1 Suicide 4 Homicide 1 See. Place of Injury 2 See. Place of Injury 3 Suicide 4 Homicide 1 See. Place of Injury 3 Suicide 4 Homicide 2 See. Place of Injury 3 See. See See See See See See See See Se	iffica or, p	C	25. Was case referred to medical					26 Place of Dea			Ass too
The bull of the property of th	s cert	OB	examiner?	Hospital:	EB/Outpation	t 3□ 00	Othe	ar.			(Specify)
30. Na' e and address person who completed cause of death (Item 23a) Prype, Print) Lenniter & Ielinger 8601 Veterans Huy M. Clers V. Cle, M. 211 C	r this			28a. Date of Injury	28b. Time o	_	8c. Injury	at			Change A 1 1 1
30. Name and address the son who completed cause of death (Item 23a) Grype, Print) Lenniter Kiesinger 8601 Veterans Huy Millers Ville, Millers All Company (Item) 21. Data filed (March Day York)	ding h. Afte fune	tion			Injury	М					
30. Na we and address reson who completed cause of death (Item 23a) Prype, Print) Lenn terk led in ger 8601 Veterans Huy Millers Ville, Mill 2110 23. Date filed (Month Day York) 23. Date filed (Month Day York)	deat deat stor: / the	ica	3 Suicide 6 ☐ Could not	be as Bloom of Injury At h	ome farm str				28f. Location (St	reet and Number	or Rumi Route Number
30. Na we and address reson who completed cause of death (Item 23a) Prype, Print) Lenn terk led in ger 8601 Veterans Huy Millers Ville, Mill 2110 23. Date filed (Month Day York) 23. Date filed (Month Day York)	or A or A Direction by	ırtif	4 Homicide determine	building, etc. (Speci	fy)	eet, lactory	, once				or riards riodio realization,
30. Name and address reson who completed cause of death (Item 23a) Trype, Print) Lennter Kiedinger 8601 Veterans Huy Millers Ville, Millers All C	urs s arel I		000 C-441-1 177 h	Managara Taraba baran San	lad			1			
30. Na he and address reson who completed cause of death (Item 23a) Trype, Print) Lenniter Kiedinger 8601 Veterans Huy Millers Ville, Mill 2110 21. Date flood (Marth Day York)	Fune Fune Fune	ica	(Check only 2 Medical Ex-	eminer: On the basis of examina	owledge, deat ation and/or in	n occurred a vestigation,	at the tim , in my op	ne, date and place, pinion, death occur	, and due to the ca rred at the time, d	ause(s) and manna ate and place, and	er as stated. I due to the cause(s)
30. Male and address derson who completed cause of death (Item 23a) (Fype, Print) Lenniter Kiedinger 860 Veterans Huy Millers Ville, Millers All (Item 23a) (Fype, Print)	hin 2 the nplet	Med		and manner stated.			Liones	number		9d Data signed "	Month Day Vocal
21 Data filed (Month, Day, Voor) 22 Partitoria Signature	1 wit	-	250. Signature and title of certifler		w	11) 290	Dise	5072<	. 2	LL 11) (i) (i)
21 Date filed (Manth, Day, Voor) 22 Page Strate Cignotius				100	/		400	, , , ,		1 11 -	2005
21 Date filed (Manth, Day, Voor) 22 Page Strate Cignotius			30. Na e and address erson wh	o completed cause of death (Ite	n 23a) Fypg.	Print)	11	. 11	11	11 1	A All AD
State 31. Date filed (Month, Day, Year) / 32. Re Strar's Signature			Jenning Kied	iriger sou	1 vet	erans	stu	W1/1/11	VersV.	Ue, M	1) 91108
Registrar APR 1 2 2005	Sta	ate	31. Date filed (Month, Day, Year)	32. Resistrar's Sign	ature	1 .	Ø .	U		,	

Amended #10e, nls, 04/20/05, Allegany County

	703, ATTO	yuı		State of N	/larylan		artment of H		Mental Hy	giene		
		-	For Stata Registrar		Death		Reg. No.	005	5335			
-	Dhuaiair		1. Decedent's Name (First, Midd						2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		SAVILLA EI	LIZABETH	SUMM	ERS			April	16,	2005	2:30 A. ^M
	Examin	er	4a. Facility Name (If not institution		er)		4b. City, Town, or		th		County of Death	
			Cumberland N 5. Social Security Number		Ane (in vrs	last birthday)	Cumber If Under 1 Year	land If Under 24 Hrs	8. Date of Birt		Allegany	
	Funeral Director		093–24–9903	1 □ M 2 □XF	92	Yrs.	Months Days	Hours Min	. (Month, Da	y, Year)		lace (State or Foreign try) VIRGINIA
	ס		Usual Residence of Decedent						DLI I . Z	2113		
	show	<u>.</u>	10a. State 10b. County			y, Town or Lo					11	0d. Inside City Limits 1
	8a-f	Director		EGANY		JMBERL!				10- Cist-	of 14/h Cours	
	with the		10e. Street and Number 110 Reynolds -110-RAYNOLDS-	Street			10f. Zip Code 21502			-	en of What Coun	try r
	ns 23	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.	.S. 13.1	Was Decedent of H	ispanic Origin? (Specify Yes or No	7	4. Race - Americ	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. Tarked other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show matic event, if a Madical Examinar must be notified at	by Fun	1 Never Married 2 Ma	If Yes, Give	XΝο		lf Yes, specify Cuba 1 □ Yes 21 X 1No	n, Mexican, Pue Specify:	rto Rican, etc.)		Black, White, of Specify: WH]	
5-0036	hours tural'		3 N Widowed 4 □ Divorce	Year or Dates	s: 	16a Decer	dent's Usual Occup	ation		16h Kin	d of Business/Inc	
2	In 72 n "na Nadie	Completed	(Specify only high	est grade completed)	- F. \	(Give	kind of work done of DO NOT use retired	during most of wo	orking		LY-SPRIN	•
2121	d with giene, or that	mo	Elementary/Secondary (0-12)	College (1-4c	or 5+)	CAFI	ETERIA WO	RKER		TIR	E COMPAN	1 Y
ם	al Hyg	Вес	17. Father's Name (First, Middle						me (First, Middle,			
aryiand	should bund Ment	스		CKLEY				DAISY			LETON	
Nar	2 2 20 20		19a. Informant's Name/Relation BARBARA O'NEA		D		ng Address (Street REYNOLD			. ,		Code) .502
e)	item 27		20a. Method of Disposition	U / DAOGITE	20b. P	Place of Dispo	sition (Name of		Date		ation - City or To	
nor	ages int of t: If it y or o		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (te l		natory or other place OD CREMAT		0/2005	CTI	MBERLANI) MD
altimore,	permit. Pages 1 a Department of He Important: If item any injury or othe		21. Signature of Funeral Service		1001		2. Name and Addre	ss of Facility	-		I IDDIOS/IIVE	,, 110
ä	Der Imp		Youxa 9	teacher	2		UPCHURCH 202 GREE				D, MD 2	21502
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause tonly one cause on each	sed the deat	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-a M	YOC	ARI	- A /	The second state of	RCTIO		25	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):	alahara kasadan , M	1000000008/4119				
		- a	Sequentially list conditions,	b. Due to (or a	as a conseq	uenne of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\								
ó	cate be executed physician and the burial-transit	Еха	resulting in death) Last	Due to (or	as a conseq	uence of):						
8760,	cate be ex physician the buria	dlcal		d								
9	ing ph	ab 1	IF FEMALE:									
Вох	eath certific attending p for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth	2 Feta	I death 3	☐Ectopic pregnancy ☐ Other (specify)	,		2	3d. Date of delive Month	ry Da y Year
o.	that the de ed by the a detached t	yslc	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		eatii 5	Cities (specify)					
<u>α</u>			Part II. Dther significant condit	ions contributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco us	se contribute to th	e cause of death?
rds	quires in sign	ed by	DIABBLE	S MELL	1705				10	res 2□	No 3 ☐ Prob	ably 4 Unknown
Vital Records,	aw requires been so should	Completed							24a. Was	an	24b. Were autop	osy findings available
Ä	The I	mo								rmed? 2 ☑ No	death?	2/2 No
ita	sician: The law certificate has b irector, page 2 s	Bec	25. Was case referred to medic examiner?	7					eath (Check only c	ne)		
of \	Physician: r this certifica ral director,	၉	1 Yes 2 No			ER/Outpatier		4 Mulsing	Home 5 Resid)
on c	iling Phye J. After this funeral di	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pend	ing .	Day Year)	28b. Time o Injury	Wor	yat k? Yes 2∐No	28d. Describe I	iow injury	occurred	
Division	l or Attendi after death. Director: A	ficat	3 ☐ Suicide 6 ☐ Could	tigation I not be mined 28e. Place of	Injury - At h	ome, farm, sti	reet, factory, office		28f. Location (S	Street and	Number or Rura	l Route Number,
<u>></u>	after after Direct	Certification:	4 Homicide	building,	etc." (Specif	(y)			City or Tox	vn, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1. Certify (Check only 2 Medica	ing Physician: To the be Il Exemîner: On the basis	est of my kno	owledge, deat	h occurred at the tir	ne, date and place	e, and due to the	cause(s)	and manner as st	ated.
	the Hin 24 the Fi	Medical	one)	and manner	stated.							
		2	29b. Signature and title of cert				29c. Licens	e unimper	200	290. Date	signed (Month, I	ray, rear)
•	5		Sm	Silver	of doub (lice	n 23a) (T	Print)	7740	W.	1	1/10/	40
	MK		30. Name and address of person	hanna	12	3.16	Mation	al High	L mars	No	le M	021502
	Sta Registi		31. Date filed (Month, Day, Yea APR 19	7) 32. Regi	istrar's Sign	ature	the same	1	J		1 , .	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of M	•	epartment of t Certificate of		Nieritai mygie Reg.	0000	1500
1	h 452		1. Decedent's Name (First, Midd		2. Date of Death	- GUU	3. Time of Death			
	Physic /Medi		Howard Tho	mpkins					Day Year 12 2005	3:38 AM
1	Exami		4a. Facility Name (If not institution	on, give street and number))		4b. City, Town, or	Location of Death	4c. County of Death	
			St. Thomas Mo					tsville		George's
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birth	day) If Under 1 Year Months Days		(Month, Dey, Ye	9. Birthi	place (State or Foreign
	Director		247-30-6490 Usual Residence of Decedent		80 "	rs.		June 13,	1924 Sout	h Carolina
	land		10a. State 10b. Count	y	10c. City, Town	or Location				10d. Inside City Limits
	Many -feh	ই	DC				Washingt	on		1 🗓 Yes 2 🗆 No
	r 28e	9	10e. Street and Number			10f. Zip Code			Citizen of What Cour	ntry?
	s 1 end 2 should be filed within 72 hours after death with the Maryland f Health end Mental Hygiene. I health end Mental Hygiene then 27 is merked other then "natural", or Items 23e or 28e-f ehow other treumatic event, the Medical Examinar must be notified at	Funeral Director	461 H St.	, N.W. #118			20001		United	States
	dea right	le l	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ Black, White,	
20	or It		1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☑ Divorce	rried 1 ☐ Yes 2 🕏 If Yes, Give	No	1□ Yes 25 No		7 (1.54.1) 5(5.7)		lack
Maryland 21215-0020	hour	Completed by	*		140- 5					
15	in 72	Set		nt's Education est grede completed)		ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of wor ad)	rking	. Kind of Business/în	Justry
712	filed with Hygiene. ther ther ent, the N	E	Elementary/Secondary (0-12)	College (1-4or	5+)				Priva	+ a
0	filed Hygie other ent,		3rd 17. Father's Name (First, Middle	, Last)		Building N		ne (First, Middle, Maid		Le
<u>a</u>	ould be i Mental arked of	To Be	11	nknown				Unknown		
ary	2 should end Men Is marke eumatic		19a. Informant's Name/Relation		19b. N	Mailing Address (Stree	t and Number or Ru			Code)
Σ	alth e		Walter Spenc	e - Friend		930 M St.,	N.W. #T-	10, Wash.,	DC 2000	1
Baltimore,			20a. Method of Disposition 1 □ Burial 2 🖾 Cremation	2 DD	20b. Place of D	isposition (Name of crematory or other pla	rce)	Date 20c.	Location - City or To	wn, State
<u>Ĕ</u>	Page nent o ant: If i	H	4 Donation 5 Other (5	Specify)		s Cremator		1/22/05	Clinton,	MD
at	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	Licensee	2	22. Name and Addre		Stewart Fu		
ш	205 20	(f) (d)	10hr/T	- Deway	VIII	4001 Be	enning Rd	., N.E. Wa	sh., DC 2	0019
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that caused t only one cause on each li	the death. Do no	t enter the mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
1	Physician		U		- 0				į Į	Onset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Se	587 S.	7.				1 cele
		5	,	Pal	Due to (or as a co	nsequence of):				
	uted Insit	Examiner		- b. / // 8	eumo	219.			2	WK
Ć.	certificete be executed rding physician end use as the buriel-transit	Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury		Due to (or as a co	nsequence or):				
68760,	te be ysicia	Medical	that initiated events	c	Due to (or as a cor	sequence of):				
89	rtifice ng ph	Med	resulting in death) Last		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4				
Вох	th ce tendii or use	an		d						
<u>.</u>	e dea the et ned fo	Sicl	Part II. Other significant condition	ons contributing to death b	ut not resulting in ti	ne underlying cause giv	ven in Part I.	23b. Did tobac	co use contribute to	the cause of death?
P.O.	The law requires that the death ce ete hes been signed by the ettendi page 2 should be detached for use	Physiclan/	Decalail	Lul.				1 🗆 Yes	2□ No 3 Serot	pably 4 ☐ Unknown
	res the signer libe of	by	20011	-03						
of Vital Records,	ne law require hes been siç ge 2 should b	Completed	Cerebro	Mascula	y QC	ciden	^	24a. Was an au performed	? ' ava	ere autopsy findings ailable prior to mpletion of cause
ခွ	hes b	de	21		ellere				of	death?
ē	: The cete		Chronic,	Renalyla	eflyxe	-		1 ☐ Yes	2 D 10	Yes 2□No
Ħ	Physician: r this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:		Ott	or.	th (Check only one)		
ō	Phys this raldi	<u>و</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie	ent 2 ☐ ER/Outpa ry 28b. Tim	attent 3LJ DOA	4 V Nursing H	ome 5 Residence 28d. Describe how in)
o	ding h. After fune	盲	1 Natural 5 ☐ Pendir 2 Accident investi	ng (Month, Day	y Year) Inju	ıry Woi	rk? Yes 2 □ No	200. 0000/100 1100	july occurred	
Division	Attending or death. ector; After by the fune	Eg	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Injuring	ury - At home, farm	, street, factory, office		28f. Location (Street	and Number or Rura	l Route Number,
Ö	s efter	Certification:	4 ☐ Homicide	building, etc	c. (Specify)			City or Town, Sta		
	To the Hospital or Attending Physician: The Is within 24 hours effer death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the best of	of my knowledge, d	eath occurred at the tir	me, date and place,	and due to the cause	(s) and manner as st	ated.
	To the Ho within 24 I To the Fu completely	ledical	one)	Examiner: On the basis of and manner sta	examination and/c	or investigation, in my o	ppinion, death occur	red at the time, date a	ind place, and due to	tne cause(s)
	Vith Com	Σ	29b. Signature and title of certifie	΄ Λ . ,		29c. Licens	e number		ate signed (Month, L	Jay, Year)
			1. Cin	2		1176	,07.	4.	13.03	
0	R (3)		30. Name and address of person	who completed cause of d	eath (Item 23a) (Ty	rpe, Print) RA	MAN	L. TUL	1- 11)	
	,		31. Date filed (Month, Day, Year)	2 Registr	ar's Signature	MOUNT,	RAINI	ER MD	20712	•
П	Sta Registr		ADD 9 9 7	005	K A	mad!				

DHMH 16 Rev 6/95

			For	State of Mar	yland / Dep	partment of I	Health and N	-	-	15337
			1 - State Registrer			ertificate of	Deatri		g. No.	
	Physicia		1. Decedent's Name (First, Middle, L George Konstan	•	ıs			2. Date of Death Month April 18	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, o	or Location of Death	1	4c. County of De	ath
			Holy Cross Hos	pital		Silv	er Spring	ŗ	Montgo	mery
	Funeral Director		5. Social Security Number 6. 577-28-8462 Usual Residence of Decedent	Sex 7. Age 1	(In yrs. last birthda 94 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 2:	^{Year)} 9. B 3, 1910 G	irthplace (State or Foreign Country) TEECE
and	≹ ₩		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Mary	de de	ō	Maryland	Montgomery	C: 1.,	er Spring				1 Yes 2 XNo
the	289	Funeral Director	10e. Street and Number	Honegomery	DIIV	10f. Zip Code		10	Og. Citizen of What (Country?
with	3a o		10710 Francis	Drive		2	0902		US	Α
deat	ma 2	ner	11. Marital Status	12. Was Decedent Ev	er in U.S. 13	3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ап	nerican Indian,
after	or it	교	1 Never Married 2 Married	Armed Forces? 1XOX'es 2 ☐ No If Yes, Give		1 ☐ Yes 21 No		rican, etc.)	Black, Wh	
Suno	2 2	d by	3 Widowed 4 ☐ Divorced	Year or Dates:19	42-45	10 105 221140	Spacity.		Specify: Wh	
72 h	natr	Completed	15. Decedent's (Specify only highest g	Education rade completed)	(Giv	edent's Usual Occup we kind of work done	during most of work	king	16b. Kind of Busines	s/Industry
with in	han Ma	m	Elementary/Secondary (0-12)	College (1-4or 5+))	. DO NOT use retire				_
Tilled A	Hygie thar I		17. Father's Name (First, Middle, Las	3	R	estaurant		e (First, Middle, M	Self-Empl	oyed
d ba	ad o	Be	Konstantinos T					ndra Bou	,	
hould	d Me mark matic	2	19a. Informant's Name/Relationship		10h Ma	iling Address /Strae			City or Town, State,	Zin Codo!
d 2 s	trau		Constantine G.						_	, MD 21042
ב ת מ	E E		20a. Method of Disposition	- journas, 201	20b. Place of Dis	position (Name of		Date	20c. Location - City of	
ages	# # X		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec			ematory or other pla eaven Cemete		1 22,		
Demit. Pages	Depurtment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or itema 23s or 28s-f show any njury of other traumatic event, the Medical Examplant must be notified at once.		21. Signature of Funeral Service Lic		1					ing, Maryland
	P F P		J. Kon Stile		5 5	rancıs J. 00 Univer	Collins sity Blvd	Funeral . W. Sil	Home Inc. ver Sprin	g,MD 20901
	H		23a. Pan1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that caused the caused the cause on each line	he death. Do not e					Approximate Interval Between Onset and Death
	jsician Medical		disease or condition resulting in death)			t Failure				Years
	aminer				consequence of):	C3:	az			V400000
		ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of:	Cardiomyo	patny			icais
uted	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
/ OU, te be executed	an an rial-tr		resulting in death) Last	Due to (or as a	consequence of):					
	ed by the attending physician and detached for use as the burial-transit	icai	•	d						
The law requires that the death certificat	ng pt	hysician/Med	IF FEMALE:							
ath cer	tendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2		3 □Ectopic pregnanc	:y		23d. Date of d	
e de	the al	sici	1 Yes 2 No	4□ Pregnant at ti 9□ Unknown	me of death 5	Other (specify)			Mortin	Day Year
hat th	d by letach	a	Part II. Other significant conditions	contabuting to doub but	not consisting in the	under tries and the	un in Deat I	22a Did tah	and the section of	to the cause of death?
ires t	s been signed to should be deta	by	Tarri, Dator significant conductions	contributing to death but	not resulting in the	underlying cause gr	venin Faiti.			Probably 4 \Unknown
law requires t	hould	etec						-		
e law	his certificate hes b I director, page 2 s	ompieted						24a. Was ar autops perforn	24b. Were a prior to death?	autopsy findings available completion of cause of
	icate r. pag	O	**************************************					1 Yes 2		es 2 No
Ol VIII Physician: 7	certif	Be	25. Was case referred to medical examiner?	Hospital:		Ott		th Check on one	The second second second second	
2 ⁴ C	r this ral dii	. To	1 Yes 2 No 27. Manner of Death	1 2 Inpatient	t 2 ☐ ER/Outpati			ome 5 Reside 28d. Describe ho	nce 6 Other (Sp	ecify)
ding	h. Afte fune	tion	1 Alatural 5 Pending 2 Accident investigat	(Month, Day		/ Wo	rk?]Yes 2 □ No		w many doddingd	
OIVISION or Attending	deat ctor: y the	ertification:	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injur	y - At home, farm,	street, factory, office		28f. Location (St	reet and Number or F	Rural Route Number.
	after Dire	erti	4 Homicide	building, etc.	(Specify)	,		City or Town	, State)	
Hospita	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	200 Conflier (Check only ane)	hysician. To the best of aminer: On the basis of e	examination and/or	ath occurred at the tr investigation, in my	illie, uate and place, opinion, death occur	and due to the carred at the time, da	iuse(s) and manner a ate and place, and di	as stated. ue to the cause(s)
o the	ithin 2 o the omple	Med	29b. Sand title of certifier	and manner state	su.	29c. Licen			9d. Date signed (Mor	
-	3 1 8		- 4///	uuga n	m					
7			30. Ame and address of person wh	eway of des	ath (Itom 22a) (Time	a Print)	2-10 1		7-1-	, -03
			AHMED NAU	AV MO PO	BOX E	33819	gailine	15 bru	4-19	20883
	Sta Registi		APR 2.1	2005 Registrar	's Signature	raile				

	For State Registrar		C	epartment of F Certificate of				Reg. Na.		a r des	
	Decedent's Name (First, Middle, Li	ast)					2. Date of De		UU;	5	3. Time of Death
1	Francis	Thomas		Twigg			Month APRIL	Day		ear O E	21:50
ľ	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of	Death	ALIVILI		County of		1_21:50
	MEMORIAL HOSPIT	AL		CUMBERL	AND			AT	LEGA	NY	
	5. Social Security Number 6.	Sex 7. Age (In	yrs. last birtho	day) If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bird	t la			place (State or Foreig
	214-05-6252	161M 2LF 92	Yrs	s. Morario Days	110013		(Month, Da 01/30/1	913	N	Maryl	and
}	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	r Location						1	0d. Inside City Limit
5	MD Alle		•	_aVale							1 ☐ Yes 21 N
-	10e. Street and Number	gaily		10f. Zip Code				10a Citi	izen of Wh	at Cour	atov?
	11017 Arizona	Avenue			21502			109. 01.	USA	ut 0041	y.
+	11. Marital Status	12. Was Decedent Ever	in U.S.	13. Was Decedent of H	lispanic Orig	in? (Spe	city Yes or No	-	14. Race -	Americ	can Indian,
	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cuba	an, Mexican,	Puerto I	Rican, etc.)			White,	
	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗖 No	Specify:				Specify:		White
	15. Decedent's E (Specify only highest g	Education	16a. D	ecedent's Usual Occup	ation	of worki	na	16b. Ki	ind of Busi	ness/Ind	dustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- iii	Give kind of work done fe. DO NOT use retired		Or WORK!	'y				
5 -	12			Senior Super					Text		
	17. Father's Name (First, Middle, Las	•	m .				(First, Middle,		Sumame)		t s.1.
2	Alondos	V.	Twig			achel		D.	_= =		Smith
	19a. Informant's Name/Relationship	(Type, Print)		Address (Street							
j.	Thomas Twigg / son 20a, Method of Disposition	2		207 Clara Bat isposition (Name of	LLOII DI.		ate				
	1 ∑ Burial 2 ☐ Cremation 3		cemetery,	crematory or other plan					cation - Ci		
-	`4 □Donation 5 □ Other (Spec		Sunset M	Memorial Park		4/23/				,	aryland
	21. Signature of Funeral Service Lice	ensee		22. Name and Addre				-		,	
	Habet C.1	+clu /		404 Decatu	1 Stife	t o tu	mperiand	عتدد و	yıanı	410	102
	23a. Part1. Enter the disease, or cor										
	shock, or heart failure. List only	mplications that cate and he y one cause on each ine.	death. Do not	enter the mode of dyir	ng, such as o	cardiac o	r respiratory a	rrest,			Approximate Interval Between Opset and Death
	shock, or heart failure. List one Immediate Cause (Final disease or condition	y one cause on each ine. ACUTE RES			ng, such as c	cardiac o	r respiratory a	rrest,			
	shock, or heart failure. List one Immediate Cause (Final	y one cause on each line.	PIRATO	RY FAILURE	ng, such as c	cardiac o	r respiratory a	rrest,		1	Interval Between
	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. ACUTE RES Due to (or as a co	PIRATOF	RY FAILURE	ng, such as c	cardiac o	r respiratory a	rrest,		7	Interval Between
	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying	a. ACUTE RES Due to (or as a co	PIRATOR	RY FAILURE						5	Interval Between Onset and Death 1 DAY
	shock, or heart failure. List onlimediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a. ACUTE RES Due to (or as a co Due to (or as a co C. SEVERE CH	PIRATOR nsequence of) nsequence of) RONIC (RY FAILURE : : : DBSTRUCTIVE						5	Interval Between Onset and Death 1 DAY
	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. ACUTE RES Due to (or as a co	PIRATOR nsequence of) nsequence of) RONIC (RY FAILURE : : : DBSTRUCTIVE						5	Interval Between Onset and Death 1 DAY
	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. ACUTE RES Due to (or as a co Due to (or as a co C. SEVERE CH	PIRATOR nsequence of) nsequence of) RONIC (RY FAILURE : : : DBSTRUCTIVE						5	Interval Between Onset and Death 1 DAY
	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACUTE RES Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co	PIRATOR nsequence of) nsequence of) RONIC (nsequence of)	RY FAILURE : : : DBSTRUCTIVE				ASE	22d Pate		Interval Between Onset and Death 1 DAY 2 DAYS
	shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d.	PIRATOR Insequence of I RONIC (I RONIC (I	RY FAILURE : : : : : : : : : : : : : : : : : : :	E PULM			ASE	23d. Date (of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS
	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a. ACUTE RES Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d.	PIRATOR Insequence of I RONIC (I RONIC (I	RY FAILURE : : : : : : : : : : : : : : : : : :	E PULM			ASE		of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS
Physician/Medical	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No	b. PNEUMONIA Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of pi Ukive birth 2	PIRATOR Insequence of Insequence of INSEQUENCE OF INSEQUEN	RY FAILURE : : : : : : : : : : : : : : : : : : :	E PULM		Y DISEA	ASE	Month	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS
by Physician/Medical	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. ACUTE RES Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of p. 1 Live birth 2 4 Pregnant at time 9 Unknown contributing to death but no	PIRATOR Insequence of) RONIC (Insequence of) regnancy Fetal death of death	RY FAILURE : : : : : : : : : : : : : : : : : : :	E PULM		Y DISEA	ASE	Month	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS ery Day Year ne cause of death?
sted by Physician/Medical	shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. ACUTE RES Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of p. 1 Live birth 2 4 Pregnant at time 9 Unknown contributing to death but no	PIRATOR Insequence of) RONIC (Insequence of) regnancy Fetal death of death	RY FAILURE : : : : : : : : : : : : : : : : : : :	E PULM		Y DISEA	ASE obacco u Yes 2	Month use contrib	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS 9ry Day Year ne cause of death?
sted by Fillysiciallymedical	shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. ACUTE RES Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of p. 1 Live birth 2 4 Pregnant at time 9 Unknown contributing to death but no	PIRATOR Insequence of) RONIC (Insequence of) regnancy Fetal death of death	RY FAILURE : : : : : : : : : : : : : : : : : : :	E PULM		Y DISEA	obacco u Yes 2 l	Month use contrib No 3 24b. We	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS 5 YEARS 5 Pry Day Year 1 Day 4 Unknow 1 Day findings available 1 Day findings available 1 Day 1
completed by rugsicial medical	shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. ACUTE RES Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of p. 1 Live birth 2 4 Pregnant at time 9 Unknown contributing to death but no	PIRATOR Insequence of) RONIC (Insequence of) regnancy Fetal death of death	RY FAILURE : : : : : : : : : : : : : : : : : : :	E PULM	ONAR	Y DISEA 23e. Did t 1 1 24a. Was auto, perfect 1 1 Yes	obacco u Yes 2(an an an an an an an an an an an an an	Month use contrib No 3 24b. We prie	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS 5 YEARS 5 YEARS 5 YEARS 5 Year Day Year 1 Day Year 1 Day 4 Unknown psy findings availably 1 Days findings availably 1 Da
be completed by railysicial medical	shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions HYPERTENSION, DI	a. ACUTE RES. Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of property of the contributing to death but not ABETES MELLI	PIRATOR Insequence of Insequence of RONIC (Insequence of) regnancy Fetal death of death of resulting in the TUS	RY FAILURE : : : : : : : : : : : : : : : : : : :	E PULM	ONAR of Death	Y DISEA 23e. Did t 1 1 24a. Was auto; performed to the control of the control o	obacco u Yes 2(an Dry Dry 22No	Month use contrib No 3 24b. We pride dec	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS 5 YEARS 5 YEARS 5 YEARS 5 Year Day Year Day Year Day 4 Unknown psy findings availably mpletion of cause of 2 \(\subseteq \text{No} \)
to pe completed by mysicial meaning	shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ACUTE RES. Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of public live birth 2 4 Pregnant at time 9 Unknown CONTRIBUTION TO ABETES MELLI Hospital: 1 Inpatient	PIRATOR Insequence of Insequence of RONIC (Insequence of) regnancy Fetal death of death It resulting in the TUS	RY FAILURE : DBSTRUCTIVE : 3 Ectopic pregnance, 5 Other (specify) ne underlying cause give	PULM ren in Part I. 26. Place	ONAR of Death	23e. Did t 1 1 24a. Was auto; performer of Check only of the control of the contr	obacco u Yes 2(an Disy Dirmed? 2 No one) dence	Month Ise contrib No 3 24b. We prie des 1 6 Other	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS 5 YEARS 5 YEARS 5 YEARS 5 Year Day Year Day Year Day 4 Unknown psy findings availably mpletion of cause of 2 \(\subseteq \text{No} \)
to be completed by Physician/Medical	shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions HYPERTENSION, DI 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	ACUTE RES. Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of principle of the contributing to death but not LABETES MELLI Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yee	PIRATOR Insequence of Insequence of RONIC (Insequence of) regnancy Fetal death of death It resulting in the TUS	RY FAILURE DBSTRUCTIVE Other (specify) The underlying cause ground attent 3 DOA Other of 28c. Injury	PULM ren in Part I. 26. Place er: 4 □ Nur y at	ONAR of Death	Y DISEA 23e. Did t 1 1 24a. Was auto; performed to the control of the control o	obacco u Yes 2(an Disy Dirmed? 2 No one) dence	Month Ise contrib No 3 24b. We prie des 1 6 Other	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS 5 YEARS 5 YEARS 5 YEARS 5 Year Day Year Day Year Day 4 Unknown psy findings availably mpletion of cause of 2 \(\subseteq \text{No} \)
to be completed by Physician/Medical	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ACUTE RES. Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of pi Live birth 2	PIRATOR Insequence of) Insequence of) RONIC (Insequence of) Insequence of) Insequ	RY FAILURE : DBSTRUCTIVE : 3 Ectopic pregnance 5 Other (specify) ne underlying cause grave attent 3 DOA Other of 28c. Injury	PULM ren in Part I. 26. Place ier. 4 □ Nur	ONAR of Death	23e. Did t 1 24a. Was auto; perfc 1 Yes 1 (Check only one 5 Resident) 28f. Location ()	obacco u Yes 2(an Desy Desy Desy Desy Desy Desy Desy Desy	Month use contrib No 3 24b. We pring det 1 [6 [Other y occurred	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS 5 YEARS 5 YEARS 5 YEARS 5 Year Day Year Day Year Day 4 Unknown psy findings availably mpletion of cause of 2 \(\subseteq \text{No} \)
to be completed by Physician/Medical	shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ACUTE RES. Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of put to pregnant at time 9 Unknown CONTRIBUTION TO BETTER MELLI Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) Due to (or as a co d.	PIRATOR Insequence of) Insequence of) RONIC (Insequence of) Insequence of) Insequ	RY FAILURE : DBSTRUCTIVE 3 Ectopic pregnance 5 Other (specify) ne underlying cause give attent 3 DOA Other of attent 3 DOA Other of attent 3 DOA Other of attent 3 DOA attent 3 DOA 1 DOA	PULM ren in Part I. 26. Place ier. 4 □ Nur	ONAR of Death	23e. Did t 24a. Was autor perform 1 Yes (Check only of me 5 Resir	obacco u Yes 2(an Desy Desy Desy Desy Desy Desy Desy Desy	Month use contrib No 3 24b. We pring det 1 [6 [Other y occurred	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 2 DAYS 5 YEARS 2 DAYS 2 DA
Certification: To Be Completed by Physician/Medical	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. ACUTE RES. Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of principle of the contributing to death but not CABETES MELLI Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yebuilding, etc. (See Physician: To the best of means)	PIRATOR Insequence of) RONIC (Insequence of)	RY FAILURE : DBSTRUCTIVE 3	26. Place or: 4 \(\to \) Nur y at k? Yes 2 \(\to \)	ONAR of Death	23e. Did t 1 24a. Was autor perficulty and fue to the	obacco u Yes 2(an osy one) dence (how injur Street an wn, State	Month use contrib No 3 24b. We princed to dear	of deliver	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS
Certification: To Be Completed by Physician/Medical	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ACUTE RES. Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of pi Live birth 2	PIRATOR Insequence of) RONIC (Insequence of)	RY FAILURE : DBSTRUCTIVE 3	26. Place or: 4 \(\to \) Nur y at k? Yes 2 \(\to \)	ONAR of Death	23e. Did t 1 24a. Was autor perficulty and fue to the	obacco u Yes 2(an osy one) dence (how injur Street an wn, State	Month use contrib No 3 24b. We princed to dear	of deliver	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS
Medical Certification: To Be Completed by Physician/Medical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ACUTE RES. Due to (or as a co b. PNEUMONIA Due to (or as a co c. SEVERE CH Due to (or as a co d. 23c. If yes, outcome of pi Live birth 2 4 Pregnant at time 9 Unknown contributing to death but not LABETES MELLI Hospital: 1 Impatient 28a. Date of Injury (Month, Day Ye on be 28e. Place of Injury building, etc. (S	PIRATOR Insequence of) RONIC (Insequence of)	RY FAILURE : DBSTRUCTIVE 3	26. Place er: 4 \(\text{Nur} y at k? Yes 2 \(\text{N} me, date and pinion, death	ONAR of Death	23e. Did t 1 24a. Was autor perficulty and fue to the	obacco u Yes 2 [an Disy Disy Disy Disy Disy Disy Disy Disy	Month use contrib No 3 24b. We princed to dear	of delive	Interval Between Onset and Death 1 DAY 2 DAYS 5 YEARS 5 YEARS 5 YEARS 5 YEARS 6 YEARS

DHMH 17 Rev 1/2001

State Registrar RANJITHAN, N.A., M.D.
31. Date filed (Month, Day, Year)
APR 2 2 2005

TIRS

CUMBERLAND, MD 21502

517 OLDTOWN RUAD, 22. Registrar's Signature

202. Location - City or Town, State Comparison City or Town, State	Just 05-0	in <mark>Chri</mark> 2882	st	opher Vaughn	Type or Print in B	lack In	ndelible	lnk.	Ensure .	All Copie	s Are	Legible.	
TOTAL CONTRICTOR CONTRICT	RJ			1- For Unpend Item Registrar	23a&27 per me	G 844₽	angren	tas	aith and	Mental H	ygien Reg. N	2005	15339
April 25, 2005 Col. 15, 15, 15, 15, 15, 15, 15, 15, 15, 15,		Physici	an		,	-						ay Year	
Forest Control Contr		/Medic	cal			N	4b. City,	Town, or L	ocation of Dea		25,		
The content of the	2	Formul				ast birthday		verly	√ If Under 24 Hr	S. 8 Date of F	Pligth	rince Ge	orges
Month 100. County 100.	3			unk 1		* * * * * * * * * * * * * * * * * * * *	Months	Days	Hours Mir			23 Wasi	nington,DC
State Control Contro	48	ryland how			10c. City	, Town or L	ocation						10d. Inside City Limits
State Stat		the Ma	ecto		George's U	pper					100.0	itizan of Mhat Co	
State Control Contro		3a or	0		Terrace								, on the year
State Control Contro		death	nera		12. Was Decedent Ever in U.S		Was Deced	ent of Hisp	anic Origin? (Specify Yes or N		14. Race - Ame	
State Control Contro	936	urs after al', or It	þ		1 ☐ Yes 2 🗷 No If Yes, Give	:		_		nto moan, etc.)			
State Control Contro	15-0	"netur	ieted			(Give	B kind of wor	k done du	on ring most of w	orking	16b.	Kind of Business/	Industry
State Control Contro	212	d withly giene. er then	omo	_ '	College (1-4or 5+)			e retirea)			ı	None	
Proposition Proposition	and	ed at b %	Be					1	_			en Surname)	
Proposition Proposition	ar y	should nd Me mark imatlo	ĭ			19b. Maili	ing Address	(Street an				or Town, State, 2	Zip Code)
Proposition Proposition	Ž	5 2 E E		Michael Vaughn	<u> </u>	1							
Proposition Proposition	ore			1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	ematory`or of	ther place)					
Proposition Proposition	Ħ	artmer ortant injury							- (P ille -		-		
Approximate properties of the destination of the complete of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode of dying, such as cardac or respiratory areast, inference and name of the mode Ba	Ded Impa		16/16					J					
Complications of Prematurity Sequentially list conditions Due to (or as a consequence of):				23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death							11027 101	Approximate Interval Between
Due to (or as a consequence of): Sequentially list conditions cause. Error Underlying Cause (business of silvery) and the conditions cause. Error Underlying Cause (business of silvery) assuling in death) Last Due to (or as a consequence of):				disease or condition			Premat	turit	у				Onset and Death
flam, landing to immediate flam, landing					Due to (or as a consequ	ience of):							
The complete of the complete		p #		if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ience of):							
98 STATE 1 FEMALE: 23d. Date of delivery Month Day Year 24d. Was an authory Deformed? Deformed? Deformed? Date of delivery Month Day Year 24d. Was an authory Deformed?		xecute and il-trans	хаш	that initiated events	c	ence of):							
1 Yes 2 No 3 Dinknown S Unknown	760		caiE		d								
1 Yes 2 No 3 Dinknown S Unknown	89	artificating physe as the	Medi	IF FEMALE:						*			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light Act 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	Bo	eath ce attend I for us	clan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	death 3							,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light At A 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	Ö.	at the d by the tached	hysi	9 Unknown	9□ Unknown								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Lite of the person who completed cause of death (Item 23a) (Type, Print) The Lite of the person who completed cause of death (Item 23a) (Type, Print) State 31. Date liled (Month, Day, Year) Registrar's Signature	ds, I	ires th; signed d be de	by	Part II. Other significant conditions of	ontributing to death but not resu	ilting in the u	underlying ca	ause given	in Part I.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light Act 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	cor	w requ	letec				-						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light At A 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	Re	The la	ошо							aut	opsy formed?	prior to death?	completion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light At A 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	/ital	sien: ertifica ictor, p	a	examiner?					6. Place of De			0, 12,00	20110
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light Act 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	of V	Physic this co	P	Yes 2□ No	1 🗆 Inpatient	-		Α					city)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light At A 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	ono	ding I th. After funer	tion	Natural 5 Pending						28d, Describe	now inji	ury occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light At A 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	is is	r Atter ter dea irector i by the	tifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	me, farm, st	reet, factory	, office		28f. Location City or To	(Street a	and Number or Ru te)	ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light At A 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature	۵	pitel o		26a Cartifier 1 Cartifulna Bh	minimum. To the beat of multiple								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This Light At A 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) Registrar's Signature		n 24 ho	edica	(Check only A Medical Exam	niner: On the basis of examinati	viedge, deat ion and/or in	th occurred anvestigation,	it the time, in my opin	ion, death occ	e, and due to the urred at the time	e cause(: e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7. TBILL CAH AL 111 PENN STREET, BALTIMORE, MARYLAND 21201 State 31. Date liled (Month, Day, Year) 32. Registrar's Signature		To the comp	Š	29b. Signature and title of certifier	010 -				umber		29d. D	ate signed (Month	n, Day, Year)
State 31. Date liled (Month, Day, Year) . Registrar's Signature				· lativel	KNAM							,	
ODDE TO THE OTHER PROPERTY OF THE OTHER PROPERTY OTHER PROPERTY OF THE OTHER PROPERTY OF THE OTHER PROPERTY OF THE OTHER PROPERTY OF THE OTHER PROPERTY OF THE OTHER PROPERTY OF THE OTHER PROPERTY OTHER PROPERTY OF THE OTHER PROPERTY OTHER PRO	C/2			7.00 Name and address of person who comes address of person address of perso	completed cause of death (Item	23a) (Type, 111	PENN S	STREE	r, balī	TIMORE, M	ARYL	AND 212	.01
THE PARTY OF THE P			1.0	31. Date liled (Month, Day, Year) MAV 9 2 2005		ure de	S.						

		-	For State Registrar	State of I		d / Depa		of Hea	alth an	d Mental) 0 5	15340
ı	Physici /Medic	an al	Decedent's Name (First, Middle, Shirley L. Vail							Mont	1 14	05	3. Time of Death 23:40 M
	Examin Funeral		4a. Facility Name (If not institution, Sacred Hear 5. Social Security Number	+ HOSPI	tal	last birthday)	4b. City, To	mbe Year If	Under 24	nd	of Birth	FILEGO 9. Bir	thplace (State or Foreign
7	Director		232-58-0060 Usual Residence of Decedent 10a. State 10b. County	1□M 2) ▼ F	68	Yrs.		Days F	Hours 1		in, Day, Year) Iul-1936	C	st Virginia 10d. Inside City Limits
chard Again	r 28a-f shor	Irector	Maryland Alleg	any	Cress	aptown	10f. Zip C	Code			10g. Citiz	en of What C	1 Yes 2 □ No
d Z1Z15-0036	ral', or items 23a or Examiner must be	Funeral	11. Marital Status 1 Never Married 2 A Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force	ent Ever in U es? No		2150. Was Decede If Yes, specifi	nt of Hispa y Cuban, I	anic Origin Mexican, P	n? (Specify Yes Puerto Rican, et	c.)	4. Race - Am Black, Whi Specify: Whit	ite, etc.
21215-0036	than "natu	Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual kind of work DO NOT use	done duri	n ng most al	f working		nd of Business	
Maryland 2	Mental Hygi arkad other	To Be Co	17. Father's Name (First, Middle, L Alvis Workman	ast)		homen	Iakel			Name (First, A	Middle, Maiden		
more,			19a. Informant's Name/Relationsh William J. Vail 20a. Method of Disposition 1	husbar	20b. F	15711 V Plan Wispo cometery, crean berland	Winslow estion (Name matory or oth Cremator 2. Name and	Street, e of eer place) ry Address o	Cr	resaptown Date 6-Apr-200		aryland eation - City o	21502 Town, State
760,	Medical Examiner The prijativanial transit	lical Examiner	23a. Parti. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Suguestially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to c.	as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consect as a consec	quence of):	enal 2105C	fresh	TC	Re		eare	Approximate Interval Between Onset and Death ONSET AND THE THE THE THE THE THE THE THE THE THE
.O. Box 68	deam cerrind e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2 ∏ Feta ntattime of o	al death 3[⊒Ectopic p re ⊒ Other (spe				2	3d. Date of de Month	elivery Day Year
rds, P.	The law requires that the te has been signed by the page 2 should be detache	by	Part II. Other significant condition	ns contributing to dea		sulting in the c		use given i	in Part I.	23e			to the cause of death? Probably 4 Unknown
		Completed	0						-	_ _	. Was an autopsy performed? Yes 2 No	24b. Were a prior to death?	
ision	tSION OI VITAI ttending Physician: death. stor: Affer this certilics t the tuneral director.	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann Death 1 atural 5 Pendin investig 3 Suicide 6 Could referred to medical examiner?	28a. Date of (Month, ation of be 28e. Place o	Injury Day Year)	28b. Time of Injury	of 28	Other: c. Injury at Work? 1 Yes	4 🗌 Nursi	28d. Des	Residence 6	occurred d Number or F	ecify) Rural Route Number,
29a. Certifier (Check only one) 29b. Signature and title Obertress. 29c. License number 29c. License number City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title Obertress. 29c. License number 29d. Date signed (Month, License of Month,											as stated. se to the cause(s)		
•	Within To the Comp	Me	29b. Signature and title of carriers 30. Name and address of person	agon and a supplemental assume	A A	D		License n		81			2005 2005 D 21502
	h Kd St	ate	DR. Gary Way 31. Date filed (Month, Day, Year)	other 9:	25 B gistrar's Sign		Wals	HR	000	Cum	ber lan	d, M	0 21502
	Regist		APR 18	2005	. .		souls						

	Disconici		1. Decedent's Name (First, Middle, Las	(t)	, .			2. Date of Dea	ath		3. Time of Death	
	Physici /Medio		ELIZABOTA	ALL Wind	Sur	_		Month	19 2	Year_	5:100	
3	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or I	ocation of Death	4c. Count	y of Deeth		
			Villa Rosa Nur				Mitchell		Prince			
	Funeral		5. Social Security Number 6. Se 213–40–8545	DM offic	st birthda Yrs.	y) If Under 1 Year Months Days		(Month, Da	v. Year)	Cou	place (State or Foreigntry)	
	Director		Usual Residence of Decedent	63	113.			Dec. 3	, 1941	Mary	länd	
	/land		10a. State 10b. County	10c. City,	Town or	Location					10d. Inside City Limits	
	Man Man	ģ	MD Prince Ge	eorge's	В	randywine					1 ☐ Yes 2 No	
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	th wit		80 Cedarville Ro	oad		20	613		USA			
	dea dea	Funeral	11. Marital Status	12. Was Decedent Ever in U,S	. 13	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No	14. Ra	ce - Ameri	can Indian,	
2	or it	五	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 ☐ No		o i nouri, etc.,	Specia			
1215-0020	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "netural", or items 23a or 28s-f show event, the Medical Evaminar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						Wnl		
Ÿ	within 72 ene. than "net	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Dec	cedent's Usual Occu ve kind of work done . DO NOT use retire	pation during most of wor	king	16b. Kind of B	usiness/In	dustry	
2	filed withi Hygiene. sther than	통	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker	,,,,		Own he	OMA		
0	filed Hygie other	BeC	17. Father's Name (First, Middle, Last)	1_			18. Mother's Nan	ne (First, Middle,				
Maryland	should be tand Mental I	To B	Walter L. Walker	:			Ruth N	aomi Lus	sbv			
a S	nd 2 should I lith and Meni 27 is markac r traumatic e		19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	iling Address (Stree				, State, Zip	Code)	
_	1 and 2 Heelth a em 27 is		William H. Windson	/ spouse	80	Cedarvill	e Rd. B	randywin	ne, MD.	2061	3	
ore,	ages 1 and of Heelt if Item 27		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □		ce of Dis	position (Name of rematory or other pla		Date	20c. Location			
Ĕ	Pages nent of I snt: if ite ury or o		4 □ Donation 5 □ Other (Specify	Hemovai from State		tion Ceme		4/22/05	Clinto	on. M	D.	
Baitimor	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Licens	see 1/		22. Name and Addr	ace of Encility	all Fune				
D	89789) CR	truell		6512 NW C			e, MD.	ne 2071	5	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the death.						20,1	Approximate Interval Between	
	Physician		,	1						1	Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Mustart	Aic	CARCI	Long			1	harth.	
		-K	Due to (or as a consequence of):									
	ted nsit	nine	_	b. OUANI	9×	CAV	c home				44	
	be executed ician end buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or a	as e cons	equence of):				į		
08/00	e be rsicia e bur		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C. Due to /or o		equence of):				-		
_	tificet ig phy es th	ledi	resulting in death) Last	Due to (or a	a a conse	equence or.						
X D	death certificete be executed e ettending physician end of for use es the buriel-transit	cian/Medical		d								
-			Part II. Other significant conditions co	entributing to death but not result	ing in the	underlying cause gi	ven in Part I.	23b. Did t	obacco use co	ntribute to	o the cause of death	
7. 5	v requires thet the d been signed by the should be deteched	Physi						101	res 2□No	3□ Pro	bably Aunknow	
Š	res th	by										
ecoras,	requi	Completed						24a. Was a	an autopsy med?	av	ere autopsy findings ailable prior to impletion of cause	
ě	The law ate hes b page 2 s	ğ								of	death?	
20								1 □ Y	es 201 No	1[☐Yes 2☐No	
<u> </u>	sicien: The law certificate hes b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Ot	hor &	th (Check only o				
5	Phys	P	1 Yes 2 No 27. Manner of Death	1 □ Inpatient 2 □ E	R/Outpati 8b. Time	ent 3LI DOA	A Nursing H	ome 5 Resid			y)	
IVISION	ding th. : Afte	盲	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	ork?]Yes 2 □ No	200. 2000110011	ow injury occur	164		
2	Atten r dea sctor by the	100	3 Suicide 6 Could not be	28e. Place of Injury - At nor	ne, farm, s	street, factory, office				per or Rura	al Route Number,	
5	s effe	Certification:	4 ☐ Homicide determined	building, etc. (Specify)				City or Tow	m, State)			
	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only Certifying Phy	sician: To the best of my knowliner: On the basis of examination	edge, dea	ath occurred at the ti	me, date and place	and due to the	ause(s) and me	enner as s	tated.	
	the H in 24 the F nplete	fedi	one)	and manner stated.	anwor			red at the time, t	ate and place,	and due to	tne cause(s)	
	다 환 다 한	Σ	29b. Signature and title of certifier	Marie		29c. Licen	se number	1	29d. Date signe			
	(P)		, / / (The Company	3)	V	2261		7-19	- 60	(V)	
,	(5)		30 Name end address of person who c	400 60	23a) (Type	Print)	ic Ra	(ahan	4-19	70	706	
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	re ø	7 7 7 7		C. Nie.	- 47			
ľ	Registr	ar	APR 2 2 2005	Blow &	Ans	WE -						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Laurie M. Woodley State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a,pt.11,27,28a-f. per me G843 5-6-05 tas Registrar Certificate of Death 05-2761 AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year April 20, 2005 LAURIE М. WOODLEY 2:41 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | 9. Birthplace (State or Foreign Coun Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Yrs. 39 Director September 11 223-98-5233 Wisconsin Usual Residence of Decedent Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28e-f show 1 Yes 2 □ No Director Bowie MD Prince George's the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20720 6806 Irene Court death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. I important: If item 27 is marked othar than "natural", or iten any injury or other traumatic event, Iten Medical Exact of the total any injury or other traumatic event. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Food Service Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Carla Vukelic ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwight Woodley/Husband T. Street N.E. Washington, DC 20002 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 Denation 5 ☐ Other (Specify) Riverdale Crematory 5/2/05 Riverdale, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mixed drug(morphine, methadone, cocaine, tramadol, a promethazine) intoxication tmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine hysician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by Suppurative pneumonia and peritonitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No page 2 s certificate 1X Yes Division of Vital 2 No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ů Y Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 12:05 28d. Describe how injury occurred unk Certification: 4-2010 3 Year) 1 Natural 5 Pending death. 1 ☐ Yes 2 🕎 No investigation found a^M 2 Accident found Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Fural Route Number City or Town, State) 6806 Trene Court 4 Homicide found at home Glendale, Maryland within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) April 20, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Green Baltimore, Maryland 21201 pera 31. Date filed (Month, Day, Year) State 2005 Registrar

			1 For State Registrer	State of Maryl	land / Dep			Mental Hy		105	1531.0
	Physici	an	1. Decedent's Name (First, Middle, Las		T IZTINI			2. Date of Dea	ath	2005 ^{ear}	3. Time of Death
	/Medic	al	MILDRED KATH 4a. Facility Name (If not institution, give		LKEN	4h City Town	or Location of Death			unty of Death	10:50 Ам
	Examin	ier	FREDERICK MEMO		ΔТ.	FREDE		'		DERICK	
	Funeral		Social Security Number 6. Security Number	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Day	h y, Year)	9. Birthp	lace (State or Foreign
	Director		270-20-2285 Usual Residence of Decedent	92	Yrs.			Feb.27	, 1913	3 Mis	souri
	show	_	10a. State 10b. County	100	. City, Town or L	ocation				1	0d. Inside City Limits
	the Ma	ecto	Maryland Frede	rick M	t. Airy	10f. Zip Code			10a Chiron	of What Cour	1 Yes 2 No
	3a or	i Dir	4122 Larson Lane			101. Zip 0008	21771			ted Sta	
	death	nera	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puert	pecify Yes or No-		Race - Americ Black, White.	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Middical Exartil ar must be muffied at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 ☒ No		o ritodii, oto.,		ecify:	
21215-0036	2 hour	ted k	15. Decedent's Ed		16a. Dece	dent's Usual Occu	pation		16b. Kind	Whi of Business/Inc	
215	ithin 7 96.	Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retire	during most of wor ad)	king			
7	Hygler Hygler ther th		17. Father's Name (First, Middle, Last)	5+		Teacher	18. Mother's Nam	ne (First Middle		lic Sch	nools
Maryland	id be fental ked of	To Be	Norman E. Johnson					Kate Ca		·	
ary	and M s mar	-	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Stree	t and Number or Ru				Code)
Σ,	and 2 lealth m 27 i		Leonard List/ Son				Lane, Mt.	-			
Baltimore,	ages 1 nt of H :: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	-	matory or other pla	4/21	Date 2005		ion - City or To	
altin	artme ortani injury		*4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Juneral Service Licen		2	Name and Addr	natoriun ess of Facility				Virginia
ä	Depa Impo any is		Stade Ol	Ugun		lin L. Mo 5401 Řidg	lesworth ge Road, I	P. A. F Damascus	unera , Mar	I Home yland 2	.0872
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the one cause on each line.	death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory ar	rest.		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Str	OKE						
	Examiner			Due to (or as a cor	isequence oi).						
	p sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. [Underly or in jury]	Due to (or as a cor	nsequence of):						
	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of):						
3760,	ate be executed hysician and the burial-transit	ical E		. d							
3	leath certificat attending phy I for use as th		IF FEMALE:								
Вох	death certifica e attending ph id for use as tl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, oulcome of printing 1 Live birth 2 4 Pregnant at time	Fetal death 3[⊒Ectopic pregnand ⊒ Other (specify) _	СУ		23d	. Date of delive Month	ny Day Year
Ö	0 0 0	hysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown							
s, P	es ign	by	Part II. Other significent conditions of	ontributing to death but no	t resulting in the t	inderlying cause g	iven in Part I.		/		e cause of death?
ord	w requir been si should	eted						1 🗆 Y			ably 4 Unknown
Record	has has	ompleted							rmed?	prior to cor death?	osy findings available npletion of cause of
Vital	ricien: Th certificate rector, pag	e C	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2 No	1 L Yes	2 □ No
of V	di 5	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	her: 4 Nursing H	ome 5 Resid	dence 6	Other (Specify)
ion o	Attending Port death. Sector: After the funeral by the funeral	ation:	27. Manger of Death 1- Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	We	ury at ork?] Yes 2 □ No	28d. Describe h	now injury or	ccurred	
Division	after de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Sp.	At home, farm, st	reet, factory, office		28f. Location (S City or Tow		umber or Rura	l Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical C	29a. Certifier Certifying Ph (Check only 2 Medical Exam	ysicien: To the best of my niner: On the basis of exam and manner stated.	knowledge, dea mination and/or ir	th occurred at the to extigation, in my	ime, date and place opinion, death occu	, and due to the or rred at the time, or	cause(s) and date and pla	d manner as st ace, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier				se number		29d. Date si	igned (Month.	
)	2			•		Doc	60417		4/20	200	
	10		30. Name and address of person who HEMEN SHAH	completed cause of death	(Item 23a) (Type	JAS Jo	HNSON	DR. F	12508	FRICK	21702 MD
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 2 2	2005 32. Projetrar's S	Signature	Jersel 1					

	•		For State Registrar	State of Ma		d / Depa	artment o	f Health	and M	ental Hyg	Reg. No.	2005	15344
	Physicia /Medic	al	Decedent's Name (First, Middle, Las WAYNE A. Facility Name (If not institution, give			DERS		n, or Location	of Death	2. Date of Dea Month MAY	Day	Year 2005 Sounty of Deat	
養	Examin Funeral Director	er	NORTHWEST 5. Social Security Number 6. Se	1+05P1 7. Ag	TAL	last birthday) Yrs.	RA If Under 1 Y	NOAUS.	TOWN	8. Date of Birth (Month, Day 8-20-1		BALTI	
	Maryland -f show iled at	tor	Usual Residence of Decedent		10c. City	y, Town or La		TIMORE					10d. Inside City Limits 1 ☐ Yes 2√2 No
	ath with the 23s or 28c	Funeral Director	10e. Street and Number 7917 SUBET ROAD					244				USA	
020	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or iteme 23s or 28s-f show ent, the Mau Cal Examinar must be mulified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		1	Was Decedent If Yes, specify □ 1 □ Yes 2 ☑			city Yes or No- Rican, etc.)		Black, White Black, BLA	e, etc.
0-6171	within 72 ho ene. then "netur he Madical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		5+)	(Give	dent's Usual Or kind of work d DO NOT use re NSTRUCT	one during mo stired)	st of workir	ng	16b. Kin	d of Business/	
ylaliu z	s I and 2 should be filed within 72 hours after death with the Marylan If Health and Mental Hygiene. If Health and Mental Hygiene 7 thems 23s or 28s-f show fem 21s marked other than "natural", or itame 23s or 28s-f show other traumatic avent, the Marylan Examinar mant has multiled at	To Be Co	17. Father's Name (First, Middle, Last) JAMES RANDALL					18. Moth	LMA A	(First, Middle,	1	iumame)	
c, Mar	1 and 2 sho Health and Iem 27 Is m		19a. Informant's Name/Relationship (7 THELMA ANDERSON/N 20a. Method of Disposition		20b. P	7917	SUBET	RD. B	ALTIM	I Route Numbe IORE, MA	RYLA		244
aithior	permit. Peges Department of Important: If It any injury or o		1 ဩBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	1)		ING ME		PARK ddress of Faci		ES A. N	10RT0	N & SO	, MARYLAND NS F.H., INC.
	50		23a. Part) Enter the disease, or complete shock, or heart failure. List only Immediate Cause (Final			h. Do not ent	er the mode of					E, MAR	YLAND 21217 Approximate Interval Between Onset and Death
lou,	that the death certificate be executed Wed pire attending physician and detected for use as the burial transit	lical Examiner	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last		tasta a conseq	hc o	iden o ca	CINON					2 months
O. Box 68	he death certifica / the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	death 3	Ectopic pregn Other (specif				23	d. Date of del Month	iv ery Day Year
ecords, r.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions of	ontributing to death t	out not res	ulting in the u	inderlying caus	e given in Part	1.		obacco us es 2		the cause of death?
T	The law ite has b	Completed								1 ☐ Yes	sy med? 2\Qr,No	24b. Were au prior to death? 1 ☐ Yes	topsy findings available completion of cause of
on or vital	ling Phy After this uneral d	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ury	ER/Outpatier 28b. Time o Injury		Other	lursing Hor	n (Check only on me 5 ☐ Resid 28d. Describe h	lence 6		cify)
DIVISION	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined						-	28f. Location (S City or Tow	Street and m, State)	Number or Ru	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	edical	(Check only 2 Medical Examone)	niner: On the best and manner s	of examina	owledge, deat ition and/or in	h occurred at the occurred in	ne time, date a my opinion, de	and place, a path occurre	ed at the time,	date and p	place, and due	to the cause(s)
	Tot	Σ	29b. Signature and title of certifier	mo			29c. Li	cense number			29d. Date	signed (Mont	n, Day, Year)
7	7		30. Name and address of person who		death (Iten	n 23a) (Type,	Print)				دُما ٥	Cour	T ROAD
18.36	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 6	2005 32. Redist	rars Signa	ature /	1						

Pt. Known as Howlam Alexandery Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 380 3:35 PM Alexander Ma 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Since Hospital of Number 6. Sex Baltimole Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 23 Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) 1**X** M 2□ F Yrs. Director 238-52-6424 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21215 U.S.A. Funeral 5404 Nelson Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes YNO If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Madical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 ond Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2th grade Plate Mounter MD Cup Company nă 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Lee Alexander 2 Eugene Harshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health en Item 27 I 5404 Nelson Ave, Baltimore, Md Clara Alexander-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny Injury or once. = 5 * 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/7/05 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intraventricular Physician disease or condition resulting in death) /Medical Uncontrolled **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) icien and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the ettending properties of the pr IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.O. | the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 2 No 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 🗌 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Fo the within 24 hours L. To the Funarel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 320 RES-000 2005

State Registrar Hospital

completed cause of death (Item 23a) (Type, Print)

		1 - For State Registrar	State of Marylar	nd / Depa		Health and	Mental Hyg	giene Reg. No. 2	005	15346			
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last) Ma Ba 4a. Facility Name (If not institution, give s	treet and number)		4b. City, Towr	, or Location of Dea		Day 28 4c. Coi	2005 unty of Death	3. Time of Death 3.15 PM			
Funeral Director		5. Social Security Number 6. Sex 212-56-3780	myland Hosp 7. Age (In yrs. 67		If Under 1 Ye Months Day		s. 8. Date of Birti	h /, Year)	Count				
in a 13-0030 within the Marylend with the Marylend ene. than "natural; or Items 23s or 28s-f show the Wedical Examinat must be notified at	rector	Usual Residence of Decedent 10a. State 10b. County Maryland N/A 10e. Street and Number	10c. C	Balt	imore					0d. Inside City Limits			
leeth with ns 23s or must be	eral Di	1365 N. Gilmor	Street 12. Was Decedent Ever in U	J.S. 13. V	212			USA	Race - America				
ours efter d	d by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify C	uban, Mexican, Pue	nto Rican, etc.)		Black, White, e	etc.			
A I X I 3-0030 ad within 72 hours eff giene. giene "naturel", or or the Medical Exam	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11th grade	cation e completed) College (1-4or 5+)	(Give	DO NOT use ret	ne during most of w			of Business/Ind	•			
nd 2 should be file the and Mental Hy 27 Is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Ben Lemon	Octob			Carri	ame (First, Middle, e Lee W	/illi	ams				
end 2 sh end 2 sh eelth and m 27 is m		19a. Informant's Name/Relationship (Ty Ashton Baxter/	Son	1365	N. Gi		Baltim	ore,	Maryla	ind 21217			
DESIGNATION CE, INTERPLIENCE A. I.S. 10-0050 permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylen Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinat must be notified at eny injury or other traumatic event, the Medical Examinat must be notified at		20a. Method of Disposition 1											
Depa Impo		23a. Part / Enter the disease, or compl	cations that caused the dea			istersto	own RD B	alti	more, M	Approximate			
Physician /Medical Examiner		shock, or head failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	nary	hemorr	hage			Interval Between Onset and Death Zhours				
difficate be executed g physicien and as the buriel-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.												
death cert e attendin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 myenths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic pregna ⊒ Other (specify			23d.	. Date of deliver Month	ry Day Year			
law requires that the sbeen signed by the sbeen signed by the sbeen signed by the sbeen signed by the specific	ρ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying cause	given în Part I.		bacco use des 2 □ N	,	e cause of death?			
The The pege	Completed		fury disc.	ase					prior to con death?	osy findings available inpletion of cause of			
Phys rat dii	atlon; To Be	25. Was case referred to fidical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	26. Place of Death (Check or Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Report 1 Place of Injury 28b. Time of Injury 28c. Injury at Work?							7)			
LIVISION Itel or Attending Its efter death. rel Director: After	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	sity)			City or Tox	vn, State)		Route Number,			
he Hosp n 24 hou he Funei pietely fii	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred at the evestigation, in m	time, date and pla y opinion, death oc	ce, and due to the courred at the time,	cause(s) and date and pla	d manner as sta ice, and due to	ated. the cause(s)			
Totl withi Totl	W	29b. Signature and little of certifier	\$	-np	29c. Lic	P16493		29d. Date si	gned (Month, E	0ay, Year) 2005 1D 121201			
Í		30. Name and address of person who compatible of the second secon	pmpleted cause of death (Ite 2 22. Registrar's Sign		the Great	ene Stre	et Bo	Stin	me, M	10 121201			
S Regis	tate trar	MAY 0 6 2005		-	de D								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Filomena L. 12:15 A M May 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country)
Philippines 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛛 F 79 Yrs. Director 213-70-5664 Usual Residence of Decedent 10a State 10b Count 10c. City. Town or Location 10d. Inside City Limits Director Maruland Baltimore 1 ☐ Yes 2 ☑ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8621 Saxon Circle 21236 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: Filipino 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Worker 12th Grade State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LaGuardia Tomelden Enrique Juliana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David E. Bates (son) 8621 Saxon Circle, Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem'l Park 5/6/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wire of uneral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final HJCV1 worth' disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Cause (Cisease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably - Weknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SEL

Pnysician /Medical **Examiner** to the Hospital or Attending Physician: The law requires that the death certificate be executed

death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

r items 23a or 28a-f show uner must be notified at

ō

item 27 is marked other than "natur other traumatic event, the Mudical

Pages 1 and 2 should be in nent of Health and Mental I

Health item 27 i

burial-transit Be Completed Certification: To

autopsy performed? Yes 2 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 rsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 € No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

filled in within 24 hours a
To the Funeral C

Medical

Jeff

29b. Signature and title of certifier

andenn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2005

8800

29c. License number

311

1 Yes

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of I	Maryland / [Departme Certifica					iene	005	15:	348
	Physici	an	1. Decedent's Name (First, Middle, Last)			_				2. Date of Deat Month	Day	Year	3. Time o	
	/Medic	al	Warren Gaile Beaver 4a. Facility Name (If not institution, give s		orl .	4b Ci	Town o	r Location o	of Dooth	May	3,	2005 unty of Death	8:25	Рм
	Examin	er	Ivy Hall Geriatric		91)			River				altimo		
	Funeral		5. Social Security Number 6. Sex	7.	Age (In yrs. last bir	thday) If Und	er 1 Year	If Under	24 Hrs.	8. Date of Birth			place (State	or Foreign
	Director		224 20 2073	3 M 2□ F	81	Yrs. Month	s Days	Hours	Min.	oct. 14, 1	923	Vir	ginia	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside C	City Limits
	Maryl f sho	tor	Maryland Baltimore	<u> </u>	Midd	le Rive	r							2-1 No
	r 28a	Irec	10e. Street and Number				ip Code			10	Og. Citizen	of What Cou	ntry?	
	23a c	Funeral Directo	1220 Fuselage Aver	nue			2122	20				USA		
	er dea	nuel		2. Was Decede Armed Force	es?	13. Was De If Yes, s	edent of H	lispanic Ori an, Mexicar	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		Race - Ameri Black, White,		
36	hours after death with the Maryland tural, or Items 23e or 28e-f show al Examiner must be modified at	by F	1 ☐ Never Married 2 ☐ :Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1 ☐ Yes	2 X No	Specify:			Spe	ecity: Whi	ite	
21215-0036	4 within 72 hours after death with the Marylan itiene. I then "netural", or items 23a or 28a-1 show the Medical Examiner must be notified at	ted	15. Decedent's Educ	ation		Decedent's U	ual Occup	ation			16b. Kind o	of Business/In	ndustry	_
215	within 7 ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	(Give kind of life. DO NOT	use retire	during mos d)	it of working	ng				
121	illed with Hygiene. other ther		11 17. Father's Name (First, Middle, Last)			Steelwo	rker	40. 14-41-	. 4. 81	(F) + 161111		l Mill		
anc	be d a star	o Be	Dexter Boyd Beavers	5						(First, Middle, Maynard		name)		
Maryland	S D E E	P ₀	19a. Informant's Name/Relationship (Typ		196	. Mailing Addre	ss (Street			Route Number,		wn, State, Zij	o Code)	
	1 and 2 : Health ar tem 27 is		Gaile G. Beavers (S	Son)	10	645 Sou	th 11	6 Str	reet '	Tacoma,	Wash	ington	98444	1
Baltimore,	Se to Te		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Records	emoval from Sta	20b. Place of cemeter	f Disposition (fi	ame of other plac	ce)	D	ate 2	20c. Locati	on - City or T	own, State	
Ë	Pages thent of I tant: if its jury or o		*4 □ Donation 5 □ Other (Specify)			ns Of F	aith	5	5/7/2	005]	Balti	more,	Maryla	and
Bai	permit. Pag Department Important: ii any injury o		21. Signature of Funeral Service License	Pouske		Bruzo	zinsk	ss of Facilit Ci Fur Caster	ieral	Home P	A. sex,	Md. 21	221	
			23a Part1. Enter the disease, or complication of hock, or heart failure. List only on	cations that cau e cause on eac	sed the death. Do h	not enter the m	ode of dyir	ng, such as	cardiac o	r respiratory arre	est,		Approxima Interval Be	tween
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	-	Unefe	al		or	4 ce				Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence	of):	n	- 1.		N. Brown		i	1	-11
		le.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	orly:	1	cru	JOI	100		-	1 1	UMIT L
	cuted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events											
ő,	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a consequence	of):								
8760,	ate be	Physician/Medical	d											
9 x	eath certifica attending ph for use as t	/Me	IF FEMALE:	3c. If ves. outco	me of pregnancy						004	Data of dalli-		
Вох	atten atten I for u	clan	in the past 12 months?	1 Live birth	n 2 ☐ Fetal death t at time of death	3 ☐Ectopic		/			23d.	Date of deliv Month	,	Year
0	t the de by the tached	hysi	1 Yes 2 No 9 Unknown	9□ Unknow			,,,,							
S, P	es that igned h	by P	Part II. Other significant conditions con	tributing to deat	h but not resulting is	n the underlying	cause giv	en in Part I.		23e. Did tob	acco use	contribute to t	he cause of	death?
ord	w requir been si should I		Renal	100	uffic	124 Cu				1 🗆 Ye	s 2∏N	o 3 Prol	oably 4 🗆	Unknown
Vital Records,	e la has	Completed	Chronic	0/25	Agri C	400	241	J D	1 Lea	24a. Was ar autops perform 1 Yes 2	/	b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	ppsy findings impletion of a	
/ita	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?						of Death	(Check only one				
of	this al dir	-T	1 ☐ Yes 2 🛣 No	ospital: 1 □ Inp 28a. Date of I	The second second second	itpatient 3		4 X NU		ne 5 Reside			(y)	
o	ding After fune	tion	1 Katural 5 Pending 2 Accident investigation	(Month,		njury M	28c. Injur Wor	yai k? Yes 2 □	1.5	8d. Describe ho	w injury oc	curred		
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At home, fa , etc. (Specify)	ırm, street, fact	_		- 1	8f. Location (Sti City or Town	eet and Ni , State)	umber or Rura	al Route Nun	nber,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examir	ter: On the basi	s of examination an	e, death occum d/or investigati	d at the tir	ne, date an	nd place, a	and due to the ca	use(s) and ite and pla	I manner as s ce, and due t	stated. o the cause(s	s)
	o the o the omple	Med	29b. Signature and title of certifier	and manner	SIBIOU.		9c. Licens					gned (Month,		
)	r s r ŏ		*	p 1). 0		(H 3:	55	93	5	14/2	200	5
	10		30. Name and address of person who	mpleted cause	of death (Item 23a)	(Type, Print)	na		~	<i>L</i>		1		_
			Dr. JOHN	WK	+ (124	11/10	Ce,	FUS	2. 13	a th	more	MD	21221
	Sta Registi		31. Date filed (Month, Day, Year)	6 2005	istrats Signature	H A	and I							,

		1 - State Registrar			tificate of	lealth and M Death	-	Reg. No.	ΩE	15010
hysici /Medic		1. Decedent's Name (First, Middle, Last) Joseph Black, Jr.					2. Date of De Month May 2		Year	3. Time of Death J 4:55 PM
xamir		4a. Facility Name (If not institution, give st				r Location of Death			y of Death	
ineral		Franklin Square Ho 5. Social Security Number 6. Sex		ge (In yrs. last birthday)	Rosedal If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	46.	9. Birthi	place (State or Foreign ntry)
ector		216 62 4274 1 ^M Usual Residence of Decedent	M 2□F	48 Yrs.	Months Days	Hours Min.	July 14	1,1956		yland
Mor W		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
Ba-f st	ctor	Maryland Baltimore		Esse	X					1 ☐ Yes 2X No
2 or 4	Dire	10e. Street and Number 1210 East Riverside	Avenue		10f. Zip Code 2122	21		10g. Citizen of USA	What Cou	ntry?
event, the Medical Exactiner; sust be notified at	by Funeral Director		2. Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give Year or Dates:	No		lispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. Ra Bla	ice - Ameri ack, White, ify: Whi	etc.
dical	Completed by	15. Decedent's Educi (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of I	Business/Ir	dustry
eumatic event, the Ma	dwc	Elementary/Secondary (0-12)	College (1-4or	5+)	00 NOT use retired arpenter	d)		Const	ructi	on
vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			тө)	
MATIC	To	Joseph A. Black Sr.				Barbara 1				
treun		19a. Informant's Name/Relationship (Typ Barbara E. Black (I				and Number or Rura Verside A'				
0110		20a. Method of Disposition		20b. Place of Dispo	natory or other plac	ce)	Date	20c. Location	- City or To	own, State
lary o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)		Bayview C		1			·	Maryland
any injury or other treumatic once.		21. Signature of Funeral Service Licenser	Buch	22	Name and Addre Br	ůžďžinski	Funera	al Home,	P.A.	
ician dical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Alcoh	d the death. Do not entine.		ng, such as cardiac o				Land 21221 Approximate Interval Between Onset and Death I 3 Days
iner parial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	Overdose a consequence of): a consequence of):						13 Days
	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 1:2 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetel death 3	Ectopic pregnancy Other (specify)	1		1	ate of delive	ery Day Year
uid be detached f	by	Part II. Other significant conditions cont	ributing to death I	out not resulting in the u	nderlying cause giv	en in Part I.				he cause of death? pably 4 Unknown
page 2 should	Completed						24a. Was auto perfo		prior to co death?	psy findings available mpletion of cause of
director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death				
funeral dir	1; To	1 X Yes 2 No Proceedings 1 No Proceedings 1 No Proceedings 27. Manner of Death	28a. Date of Inj (Month, Da		28c. Injur	y at		dence 6 Ot		(y)
in by the fund	ation	1 Natural 5 Pending investigation	(Month, Da	y Year) Injury	M 1 □	k? Yes 2□No				
d in by t	Certification;	3 ☐ Suicide 6 ☑ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At home, farm, str cc. (Specify)	eet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rura	al Route Number,
completely filled in by	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 1 ☐ Certifying Physic 2 ☑ Medicel Examination	cien: To the best er: On the basis of and manner s	of my knowledge, death of examination and/or in- ated.	occurred at the tir restigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and m date and place	nanner as s , and due to	tated. o the cause(s)
To the Funerel completely filled	M	29b Signature and title of certifier	De	puty	29c, Licens	8667		April	3, 2	Day, Year)
7		30. Name and address of person who com Philip Militello,				Daltimore	M	21C 21C	201	
CA	ite		00 0 1	r's Signature		ратстиоте	, ratyl	and ZIZ	.01	
316				A.C.	ILAMANI I					

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and I	Mental Hy	glene 05	15350
	Division		1. Decedent's Name (First, Middle, Last)	2. Date of De	D 1/	3. Time of Death
	Physici /Medic		Vernon W. Birkelien Sr.	5	3 200	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	h	4c. County of Deat	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8 Date of Bir	BOIT	hplace (State or Foreign
	Funeral Director		217-22-2926 1⊠M 2□F 77 Yrs. Months Days Hours Min.	June 1	ay, Year) Co	yland
-	70		Usual Residence of Decedent			
	within 72 hours after death with the Maryland one one than "natural, or Itams 23a or 28a-f show than "natural, or Itams 21a or 21 he modical Examinat must be modified at	'n	MD Baltimore IOc. City, Town or Location Essex			10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the M	Funeral Director	10e, Street and Number 10f. Zip Code		10g. Citizen of What Co	
\subset	with Sa or	흐	1002 Kayden Lane 21221		USA	unity
non	death	nera	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No		
9	after or Ita		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No	(o nican, etc.)		
(O) 8	hours ural',	d by	3 □ Widowed 4 □ Divorced Year or Dates:	· · · · · · · · · · · · · · · · · · ·	SpecifyWhi	
> 5	n 72 "nat	lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wollife. DO NOT use retired)	rking	16b. Kind of Business/	•
212	jene. r thar	Completed	10th College (1-4or 5+) Carpenter		Construt	
Q P	e filed al Hyg I othe vant,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle	, Maiden Sumame)	
<u> </u>	Ments Ments arkad atic e	P O		imenser		
O C Maryland	12 sh h and 7 Is m iraum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re		-	
√ ,ø	1 and Health em 2		CharlotteBirkelien/wife 1002 Kayden Lane 20a. Method of Disposition 20b. Place of Disposition (Name of	Baltin	nore MD 21 20c. Location - City or	221 Town, State
To To	ages int of t: If it		comptany cramatony or other place)	5/05	Baltimore	
Si CK	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be redified at once.		20 Alexand Sanital Sanital Sanital	11	T 1	
	Der Per Per Per Per Per Per Per Per Per P		M. Terry Connelly 300 Mace Ave	e. Balt	yFuneralHo	meofEssex
		1717.25	23a. Part. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardial shock, or heart failure. List, in one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Acute MI	**		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	0.0	ease	
		Je.	Sequentially list conditions, if any, leading to immediate b. ATRIOSCIRIOS HEO-CT Due to (or as a consequence of):	V13	600 C	
A -	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events 6. Due to (or as a consequence of):			
ó	ate be executed sysicien and he burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
Box 68760	by S	Physiclan/Medical	d			
39	leath certifica attending ph I for use as th	Med	IF FEMALE:			
Bo)	attend for us	lan	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of del Month	very Day Year
P.O.	that the death cer ed by the attendir detached for use	iysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
۵.	ires that the signed by	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute to	the cause of death?
p	w require been sic		Ineumonia.	1 🗆	Yes 2 No 3 Pr	obably 4 Unknown
Division of Vital Records,	law re as be 2 sho	Completed	Hypertension	24a. Was	psy prior to o	topsy findings available
œ	The tate has page	Con		perfe 1 ☐ Yes	ormed? death? 2☐No 1☐Yes	2 No
Vita	Physician: The lav this certificate has ral director, page 2	Be	examiner?	ath (Check only		
ō	Phys r this ral dir	. To	1		idence 6 Other (Spec	cify)
lon	nding th. : Afte e fune	atlor	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		. ,	
Visi	Atter actor by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ((Street and Number or Ru	ral Route Number,
Ō	ital or rs afte al Dir led in	Cer	Sullaing, etc. (Specify)			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date of examination and only only of the place (2 ☐ Medicel Exeminer: On the basis of examination and only of examination and o	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month	n, Day, Year)
	1) m/n or 017728		5/3/6	5
	b		30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) Dr. Bolin Oung 9600 Franklin Square Drive	Ball	- 1-00	M D 2 1277
			Dr. Bolin Oung 9000 Fronklin Square Drive 31. Date filed (Month, Day, Year) 82. Registrar's Signature	100-17	inole	1111/10/10/11
	Sta Regist	•	MAY 0 6 2005 Reven & Soule			

Physicia /Medic		For State Registrer 1. Decedent's Name (First, Middle, Last) CHANCE	s Beo	WW.	rtificate of	R.	2. Date of Dea Month	Day	3. Time of Death
Examin		4a. Facility Name 4f not institution give s	Hospital	£	Havre D	or Location of Deat	h	4c. County	of Death -PORM
uneral irector		22.72.0106	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birt (Month, Da 2 · 16	h y, Year	9. Birthplace (State or Fore Country)
Misd at	tor	Usual Residence of Decedent 10a. State 10b. County HARFO		ty, Town or Lo	COEEN	2			10d. Inside City Lim
3e or 28	Il Director	10e. Street and Number	STEPNEY K	25	10f. Zip Code	01		10g. Citizen of W	
od other then "natural", or ltems 23e or 28e-f show event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14. Race Black	e - American Indian, k, White, etc.
hen "nature e Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	DO NOT use retir	eduring most of wo	rking	16b. Kind of Bu	siness/Industry TRUCTION
ed other then event, the M	Be	17. Father's Name (First, Middle, Last) CHARLES W	ORMAN B		GINE		me (First, Middle,	Maiden Sumam	e <i>)</i>
item 27 is marked other treumatic ev	2	19a. Informant's Name/Relationship (Ty) CAROL BROWN				at and Number or R			State, Zip Code) 2,014
		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemoval from State	Place of Disponentery, crea	osition (Name of matory or other pla		Date S-2005	20c. Location	City or Town, State
Importent: If eny injury o		21. Signature of Funeral Service License		2:	2. Name and Addi	ess of Facility EV			HAPEL BELA
ysician Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	TINC	220	ing, such as cardia	c or respiratory ar		Approximate Interval Between Onset and Death
ledical aminer purial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect.)	200	CANCE	25 CAN	10 NG	UE	2 YEAR
by the attending phy. tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3[⊒Ectopic pregnan: □ Other (specify)	су		23d. Date Mor	e of delivery hth Day Year
been signed by should be detac	by	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	Inderlying cause g	ven in Part I.			ibute to the cause of death
ate has page 2	Completed						24a. Was autop perio	rmed? d	Vere autopsy findings availarior to completion of cause leath?
certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 ⊠ Inpatient 2 □	ER/Outpatie	nt 3 DOA	thon	ath <i>(Check only o</i> fome 5 ☐ Resid		
ath. rr: After this ne funeral di	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Inju		_	now injury occurre	
ours atter death. nerel Director: Af filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	'fy)			City or Tov	vn, State)	er or Rural Route Number,
within 24 hours al To the Funerel D completely filled i	Medical	(Check only 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, deat ation and/or in	vestigation, in my	opinion, death occ	urred at the time,	date and place, a	and due to the cause(s)
To	2	29b. Signature and title of confiner	5 MD		29c. Licer	2/33	8	29d. Date signed	OZ-ZOO. TECA12
. ()		30. Name and a dress of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print)				_

5/1/05 11:15 AM

Charles BROWN

			For State Registrar	State of Marylan		rtment of Hetificate of E			iene.	5 15352
	Physici	an .	1. Decedent's Name (First, Middle, Last)		.3.064			2. Date of Dea Month	th	3. Time of Death
	Physicia /Medic		James	Broadi	NAG	# 05 T		May	03 20	305 5:55 M
h	Examin	er	4a. Facility Name (If not institution, give:	street and number)	Lehob	4b. City, Town, or BALTIMO			4c. County of	Death
	Funeral		Social Security Number 6. Sec.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthplace (State or Foreign Country)
	Director		213-68-9755)M 2□F 49	Yrs.	World Days	riouis wiit.	2-11-	-1956	MD
	land	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits
	Mary	tor	MD BALTIMO	RE	WOODLA	WN				1 ☐ Yes 2 X No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	ath w		3147 JEFFLAND ROAL			1	21244		USA	
	ter de	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	o Rican, etc.)		- American Indian, , White, etc.
036	filed within 72 hours after death with the Maryland Hygion. Ither then "natural", or items 23a or 28e-f ehow ont, It a Medical Examinat mant be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	BLACK
2	72 hc natur	Completed	15. Decedent's Edu (Specify only highest grad	cation a completed)	16a. Deced (Give	ent's Usual Occupa kind of work done d OO NOT use retired)	tion uring most of won	king	16b. Kind of Busi	iness/Industry
121	within ene. then	dmo	Elementary/Secondary (0-12)	Colfege (1-4or 5+)		LDER			RETHI.EI	HEM STEEL
2	be filed within 72 hours after death with the Marylan is Hygiene. Ide Hygiene. Ide other than "natural", or Items 23a or 28e-f show other than "natural", or Items 23a or 28e-f show event, Ite Medical Examinat man be notified at	Be Co	17. Father's Name (First, Middle, Last)		, WD		18. Mother's Nam	ne (First, Middle,		
/lar	E should be filed and Mental Hygin is marked other aumatic event, II	To B	HARLIE H. BROADWAY				OCTAVI	A LITTLE	Ē	
Maryland 21215-003			19a. Informant's Name/Relationship (Ty MARY EASTMAN/SISTE			g Address (Street a JEFFLAND				
	ges 1 and 3 t of Health if Item 27 or other tr		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of				Sity or Town, State
more,	Pages nent of I int: If It		1 XBurial 2 Cremation 3 F	lemoval from State	cemetery, crem C. STAN	atory or other place ISLAUS		9,2005	BALTIMOR	RE, MARYLAND
ati	permit. Page Department of Important: If eny injury of once.	10	21. Signature of Funeral Service Licens	99						SONS F.H., INC.
<u> </u>	20E 29	1 17	James 9	Mortor	1	701-31 LA			IMORE, M	
1%			23a. Pard. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final	ne cause on each line.	th. Do not ente			or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	quence of):	2/14	61 (0	19cer		
C.S.	Examiner		Sequentially list conditions	Maln	y tri	tion				
199	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dué to (of as a conseq	quence of):					
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a conseq	quence of):					
8760	ate be executed hysician and the burial-transit	dical		J						
9	artifica ing ph e as th	Med	IF FEMALE:							
Вох	eath certif attending for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	
o	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as:	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	10a(ii 5	Ottler (specify)				
ري ص	res that igned b	by PI	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	nderlying cause give	n in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ord	w require been sign		History	of 111	Cahol	depen	donce	1 🗆 Y	es 2∐No 3	Probably 4 Unknown
Sec.	e law i has b	Completed						24a. Was a autops perfori	sv pri	ere autopsy findings available for to completion of cause of eath?
<u>a</u>	sician: The la certificate has rector, page 2	e Co	25. Was case referred to medical				00 Pl (P	1 ☐ Yes	2/X/No 1	Yes 2 No
₹	Attending Physician: sr death. ector: After this certifica by the funeral director.	0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe	r	th (Chack only or ome 5 - Resident		(Specify)
n 0	ding Ph h. After the funeral	n; T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at		ow injury occurred	
sio	death. ctor: A ctor: A y the fu	catle	2 Accident investigation 3 Suicide 6 Could not be	00 Bloods 1			res 2□No	004 1	A	Cont. Cont. Montage
Division of Vital Records,	after death Director: Jin by the	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy)	эет, тастогу, оптсе		City or Town	n, State)	r or Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	calc	29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, death	occurred at the tim	e, date and place	, and due to the c	ause(s) and man	ner as stated.
	the H hin 24 the Fu	Medical	one)	ner: On the basis of examina and manner stated.					ш.	
	T With	~	29b. Signature and title of certifier	Maen s	MD	29c. License	5503	2	Su. Date signed ((Month, Day, Year)
	7		30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type,	Print) 1 3 1	111		1199,0	212.7
	7		30. Name and address of person who control of the c	MAEEM	501	DOLYH	IN ST	BAL	to mo	21217
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 6 2	32 degistrar's Signal	atura Ap	area.				

			1 - For State Registrar	State of Maryland			of Health a of Death		Re	g. No. 4 U	05	15	353
	Physici /Medic		1. Decedent's Name (First, Middle, Las Roy Lee Beaver						Date of Death Month April	Day 24 20	Year 005	3. Time of 5:05	Death P ^M
	Examin Funeral Director	er	4a. Fecility Name (If not institution, give Frederick Memor. 5. Social Security Number 6. Social Security Number 418–84–8357	ial Hospital	ast birthday) Yrs.	Frede	erick ear If Undersays Hours	24 Hrs. 8.	Date of Birth (Month, Day, 06/15/1	Year)	derio	ck place (State o ntry) AL	r Foreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD	Frederick 10c. City	r, Town or Lo		derick				1	10d. Inside Ci	•
	sa or 28a-	i Director	10e. Street and Number 1900 West Patri	ick Street		10f. Zip Co		1703	10	g. Citizen of V	What Coul	ntry?	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, if a Medical Evertifier invalide at ances.	by Funerai	11. Marital Status 1XDNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent If Yes, specify	t of Hispanic Ori Cuban, Mexican KNo Specify:	gin? (Specify i, Puerto Rica	Yes or No- an, etc.)	Blac	e - Americ ck, White, /: bla		
21215-0	d within 72 ho giene. ir than "natur I're Medical.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	DO NOT use r	lone durina mosi	t of working	1	6b. Kind of Bu		ndustry	
and	uld be file Mental Hyy irked othe	To Be C	17. Father's Name (First, Middle, Last) Eddie Bear				18. Mothe		irst, Middle, M NCES JU		10)		
, Maryl	and 2 sho salth and ! n 27 is ma er trauma		19a. Informant's Name/Relationship (Mildred Beaver	Type, Print) / Sister			treet and Numbe idge Roa				State, Zip 3611	_	
Baltimore,	t. Pages 1 rtment of He rtant: if itan ijury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State O	ametery, crei akwood		Cemeter	-	/30/05		mery	, AL	
Ba	Departiment of the control of the co		21. Signature of Funeral Service Licer V1C	tor P. Doda, Ji			L. Stev St. Fort				Inc. MD 2	1230 Approximate	
8760,	death certificate be executed Exam e attending physicien and id for use as the burial-transit	dicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	Party Mend	Paul	Li				Interval Battonset and I	ween Death
O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregr Other (speci			wal	23d. Dai Mo	te of deliver	*	Year
ds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of		ulting in the u	nderlying caus	se given in Part I.		23e. Did toba	acco use cont		the cause of d	
Vital Records,	The ate h page	Completed	Outile,	nellitur					24a. Was an autopsy pertorm	ed?	Were auto prior to co death? 1 🗌 Yes	opsy findings a empletion of ca 2 No	available ause of
	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 Mo	Hospital: 1 Inpatient 2 D	ER/Outpatie	nt 3 DOA	Othon		Check only one		er (Speci	fy)	
Division of	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1		28b. Time of Injury	М	Injury at Work? 1 Yes 2	No	. Describe how			al Route Num	her
ο	pital or A ours after erai Dire		4 Homicide determined 29a. Certifying Pt	building, etc. (Specify	v)				City or Town,	State)			
	To the Hospital (within 24 hours at To the Funeral D completely filled it	Medical	(Check only 2 Medical Exer	niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in	my opinion, dea	th occurred	at the time, da	te and place,	and due t	to the cause(s)
		~	29b. Signature and title of certifier	Eller	la	2 1	icense number	156		d. Date signed	110	Jay, rear)	
	5		30. Name and address of person who	completed cause of death (Item	1 23a) (Type,	Print)	1. Fra	lemb	, Ma	217			
	St Regist	ate rar	31. Date filed (Month, Day, Year) M.AY 0 6 20	de. Hegistiai s digita	iture	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Brignol, Month Year **Physician** 15 PM Catherine 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Months Days Hours 140-01-6916 93 Yrs. 03/06/1912 Director Italy Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Completed by Funeral Director MD Prince Georges Greenbelt. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4G Gardenway 20770 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 XNo Specify: 3₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Custodian Cleaning 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Negruzzi Unk. Unk. ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 Barbara Brignoli /Granddaughter 20010 Apt. 23 Sweet Gum Circle Germantown MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Aemoval from State Calvary Cemetery April 25,2005 Queen, * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tuneral Service Licensee Tom Zizos 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave. Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 48 hours Priysician Sepsis disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant atten for u 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4. Unknown Completed 24a. Was an autopsy performe ∕24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No rmed? certificate 1 Yes the Hospital or Attending Physiclan: 25. Was case referre medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) 29b. Signature and title of certifier m 23a) (Type, Print)

GAOI Medical Dr., Rockville mo. 20850 30. Name and address of person who commeted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 6

doutre

2005

Registrar's Signature

			For State Registrer	State of M	laryland / De	partment of Certificate o		-	giene Reg. No.	enos.	1 Forer
	Physici /Medic	al	1. Decedent's Name (First, Middle, L Helen Louis	e	-1	Brune		2. Date of De Month	Day 5	Year 2005	3. Time of Death 7 25 A M
	Funeral		4a. Facility Name (If not institution, g Johns Hopkins 5. Social Security Number 219-16-4705	Bayview M	ledical Center Ige (In yrs. last birtho 79	Ba/Hi		8. Date of Bir	th	Cour	place (State or Foreign
	Director 4 show		Usual Residence of Decedent 10a. State 10b. County	imore	10c. City, Town o			4-8-1	926		imore, MD Od. Inside City Limits 1 Yes 2 No
	th with the 23a or 28a 1st Le notil	Funeral Director	10e. Street and Number 7129 Eastbro	ok Aven	ue	10f. Zip Code	21224		10g. Citizer USA	n of What Cour	itry?
900	d within 72 hours after death with the Maryland Jione. Ir than "natural", or Hems 23a or 28a-1 show I're Medical Evantiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	3? ⊈ No	I3. Was Decedent of If Yes, specify C	of Hispanic Origin? (suban, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	ĺ	Race - Americ Black, White, pecify: Whi	etc.
Maryland 21215-0036	d within giene. rr than "	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 10th	rade completed) Coilege (1-4o	r 5+)	ecedent's Usual Occ ive kind of work doi e. DO NOT use ret erk	ne during most of wo	•	Beth		steel
yland	9 6 6 T	To Be	17. Father's Name (First, Middle, La Elmer Rice		Toric v		Alva	Reynes			
	is 1 and 2 should by Health and Meritem 27 is marker other traumatic		19a. Informant's Name/Relationship Sam Brunetto	(Type, Print) spo	712		rook Ave		imore	, MD	21224
Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Control	aify)	comoton:	crematory or other p ns of Fa	ith $5/7$	/2005	Balt:		Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service Lic	Zanne	vo	263 S.	dress of Facility Jo Conkling	St.Bal	Ltimo	nino C	Jr. FH D 21224
	Pnysician /Medical		23a. Part1. Enter the disease, or oc shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	aAcc	line.	cardial	infurctio		rrest,		Approximate Interval Between Onset and Death
8760, 🗸	death certificate be executed as entending physician and dior use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Exact Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	is a consequence of)						
O. Box 68	death certific e attending p d for use as	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pregna 5 □ Other (specify)			230	f. Date of delive	ery Day Year
rds, P.	es tha gned be de	by P	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying cause	given în Part I.	23e. Did to			ne cause of death?
Vital Records,	The law ate has b page 2 sl	Completed						24a. Was autor perfo 1 \(\text{Yes}		prior to cor death?	psy findings available mpletion of cause of 2 No
of Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 🔀 Inpa			Other: 4 Nursing		dence 6		y)
Division (ttending death. stor: After / the funer	ertification:	27. Manner of Death 1 Natural 5 Pending investigat 2 Accident investigat 3 Suicide 6 Could no determine	be 28e. Place of I	njury 28b. Tim njury - At home, farm etc. (Specify)	ry V M 1	Vork? ☐ Yes 2 ☐ No	28d. Describe f	Street and N		l Route Number,
Ω	spita ours ieral	edical Cer	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes	st of my knowledge, of of examination and/o	eath occurred at the	time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) an	d manner as st	ated. the cause(s)
)	To the Hos within 24 hr To the Fun completely	Med	29b. Signature and title of certifier	and manner	stated.		S- 000			igned (Month,	Day, Year)
	8		30. Name me ddress of person who Dr. Jehn Ecku	man 49	40 Eustern	pe, Print) 1 Avenue	, Baltin	more, Mi	> 21	224	
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 6 2		strar's Signature	me					

		-	For State Registrer	State of M	Maryland	_	artment of rtificate of		and M		iene	105	15356
	Dharisi		1. Decedent's Name (First, Middle	, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Mary Fran	nces Burn	S					April	26	2005	10:33 a. ^M
	Examin		4a. Facility Name (If not institution	, give street and number	er)		4b. City, Town,	or Location of	of Death			unty of Death	
			15507 Ivy Cour					berlan				llegan	
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 🛣 F	Age (In yrs. la	i <i>st birthday)</i> Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day	, Year)		place (State or Foreign ntry)
	Director	-	234-38-9024 Usual Residence of Decedent		77					June 2	1927	West	Virginia
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mar	tor	MD Alle	egany	Cı	umber]	land						1 ☐ Yes 2 XNo
	or 284	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Cou	ntry?
	23a C	alD	15507 Ivy Cou	ırt			2150	2			1	USA	
	ems ems	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S	3. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23s or 28s-f show It e Misclical Excining tribal be indiffed at	by Fu	1 Never Married 2 Marr	If Yes, Give			1 ☐ Yes 2 🙀 N	o Specify:				ecify:	
21215-0036	ural'	q p	3 X Widowed 4 □ Divorced	Year or Date	\$: 	1Co Door	death Havel Ose				105 Kind	of Business/In	White
5	n 72 "nat	Completed	15. Deceden (Specify only highe	st grade completed)		(Give	dent's Usual Occ kind of work don DO NOT use retii	e during mos	t of workii	ng	160. King c	or Business/ir	idustry
12	within iene. than "	E O	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Se	cretary	,			3 1in	Petro	leum Co.
D	Hyg Hyg ant,	BeC	17. Father's Name (First, Middle,	Last)			CIELALY	18. Mothe	er's Name	(First, Middle,			reon co.
<u>a</u>	\$ \$ \$ \$ \$	To B	Joseph Neil	Shobe, Sr.				В	erti	Norwo	bc		
Maryland	S D E E	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stree	et and Numbe	er or Rura	l Route Numbe	r, City or To	wn, State, Zij	code)
	2 = 24 =		Gregory D. Bui	rns/Son			1, Box	122-A3	8 K	eyser, I	V 26	5726	
altimore,	iges 1 and it of Healt if item 2: or other		20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal from Sta	ca	ace of Dispo metery, crei	sition (Name of natory or other p	lace)		ate	20c. Locati	ion - City or T	own, State
Ē	Pag ment ant: I		`4 □Donation 5 □ Other (S		1	een's	Point (Cemeter	Apr	i1 30 2005	Key	ser, W	V
Salt	permit. Pages Department of I Important: If ite any Injury or of		21. Signature of Funeral Service	Licensee /	1		2. Name and Add			nith Fu			
<u> </u>	<u>20599</u>		23a. Part1. Enter the disease, or	J. Dull	✓ <u> </u>		35 S. Ma			Keyse		2672	26 Approximate
8760,	/Medical Examiner	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence as a c	ence of):	0F	COLO	N				2 Y Ca V S
P.O. Box 68	at the death certific by the attending p tached for use as t	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown		2 Fetal	death 3[□Ectopic pregnar □ Other (specify)			T	23d.	. Date of deliv Month	ery Day Year
	quires the	þ	Part II. Other significant condition	ons contributing to deat	h but not resu	Iting in the u	nderlying cause (given in Part I		23e. Did to			the cause of death? bably 4 DUnknown
Records,	The law requir ate has been si page 2 should	Completed						-		24a. Was a autop perfor	sv	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?					26. Place	of Death	(Check only or	1e)		
of <	d s	To I	1 ☐ Yes 2 🔀 No		atient 2 🗆 E		IL 3 DOA		ırsing Hor			Other (Speci	fy)
Ē	ding Ph h. After th funeral	.uo	27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury	W	/ork?	- 6	28d. Describe h	ow injury o	ccurred	
sio	tend leath tor: /	catl	2 Accident investi	not be				□Yes 2□	-	206 1	44181		
Division	or All	Certification:	4 Homicide determ	sined 286. Place of	etc. (Specify)	me, tarm, sti	reet, factory, offic	8	4	City or Tow		umber or Hun	al Route Number,
7	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Co	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the be Examiner: On the basis and manner	s of examinati	vledge, deat ion and/or in	h occurred at the vestigation, in my	time, date an y opinion, dea	nd place, a	and due to the co	ause(s) and late and pla	d manner as s	stated. o the cause(s)
	To th within Fo th	Me	29b. Signature and title of certifie	or)	/	7	29c. Lice	nse number		2	29d. Date si	igned (Month,	Day, Year)
)	./		1/0017	triner		mn	7	2377	14	/	PRIL	26	2005
	15		30. Name and address of person	who completed caus	death (Item	23a) (Type,	Print)	F 9 1 1	-			1	-
	1		Paul Livengo	ood, M.D.	912 9	SETUI	U DRIVE	- Cun	NBET	CLAND	MAR	y ZAND	21502
	Sta	ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signat	ure	and I						
U	Regist	rar	NAY O	who completed caus cod, M.D. 32. Reg	بكر مرتبلو	1 19							

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1 5 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5								f can o an			
			Registrar 1. Decedent's Name (First, Middle, Last)		incate of t	Jean	2. Date of De	of Death 3. Time of Death						
	Physicia	an	GEORGE	4 ~		Month	nth Day Year							
	/Medic		4a. Facility Name (If not institution, give	RENNA	4b. City, Town, or	Location of Des		1 - 335						
	Funeral Director	er	NORTHWEST	1705 PITAL		N.	SDALLST		4c. County of Death BALT MORE					
			5. Social Security Number 6. Sec		7. Age (In yrs. last birthday)		If Under 24 Hr	S. B. Date of Bir	th	9. Birtho	place (State or Foreign			
п			213-16-5533 ¹ X	2M 2□ F 82 Yrs.		Months Days Hours Min.		December	r 24,192	ar) Country)				
			Usual Residence of Decedent											
	arytar ehow	_	10a. State 10b. County		. City, Town or Lo					1	10d. Inside City Limits			
	89-f	Directo	Maryland Baltimon	re	Baltin						1 ☐ Yes 2 🛣 No			
	with th		10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?			
	within 72 hours atter death with the Maryland ane. than "netural", or liems 23a or 28e-f ehow the Medical Examener must be notified at	Funeral	6435 Kriel Stre	et 12. Was Decedent Ever	in II C 12 1		207	C*- V N		U.S.A.	to do-			
		'n.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	In U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (in, Mexican, Pue	specify Yes or No irto Rican, etc.)		Race - Americ Black, White,				
36		by	3 ☐ Widowed 4 🎇 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: W/	III	1 ☐ Yes 2 🛣 No	Specify:		Spi	ecify: What	i to			
21215-0036		ted	15. Decedent's Edu	16a. Dece	dent's Usual Occupa	ation		White 16b. Kind of Business/Industry						
215	hin 7 an "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	kind of work done o DO NOT use retired	during most of w l)	orking								
7	er th	Con		College (1-4or 5+) 5+		Attorney		Social	cial Security Adm.					
pu	pernit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Branchant: If item 27 is marked other than "netural; or Items 23a or 28e-f ehow any njury or other traumatic event, Item Medical Exams as must be notified at once.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	, Maiden Sur	name)				
<u>yla</u>		2	George Joseph Brennan Elizabeth Grace Williamson											
Maryland		1 14	19a. Informant's Name/Relationship (Ty			ng Address (Street a								
Baltimore, 1			G. Joseph Brennan	(son)		Burke A	venue .	Cowson, N						
	if ite		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ F	lemoval from State		natory or other plac	· 1			ion - City or To				
ij	rt. Partmer rtant rtant njury		* 4 □ Donation ¯5 □ Other (Specify)			ınt Crema		-6-05	Baltin	nore, N	Maryland			
Ba	Departing Important Conces		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212											
			23a Part 1 Enter the disease or compl	cations that caused the	feath. Do not ent	OUU York	Road Ba	ltimore,	Mary	Land 21	212 Approximate			
	E . T .		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death											
	/Medical Examiner bhysician and private is the private in the priv	f (j	disease or condition resulting in death)	Due to (or as a co					2 days					
Į,				hudron					2 days					
		ē	Sequentially list conditions, if any, leading to immediate	on				1						
		Examin	cause. Enter Underlying Couse Disease unique that initiated events											
ó														
68760,		dicai	d											
	ng ph													
Вох	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d.	Date of delive	*			
	0 0 0	sici								Month Day Year				
P.0	The law requires that the site has been signed by the bage 2 should be detache								labassa usa	contributo to t	ha equipped death?			
S,	ires ti signe	by	rait ii. Other significant conditions co.				ribute to the cause of death? 3 Probably 4 Inknown							
Records,	w requir been si should	ompleted		-										
3ec	e law has l	mp			24a. Was		4b. Were auto prior to con death?	psy findings available mpletion of cause of						
a		O						1 ☐ Yes	2 X (No	1 Yes	2 No			
Vital	5 8 9	o Be	25. Was case referred to medical examiner?	lospital:						th (Check only one)				
of		\vdash	1 Yes 2 No	4 ∐ Nursing	ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred									
on	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer.	tlor	1 Natural 5 Pending 2 Accident investigation	yat k? Yes 2 □ No		,,	,							
Division		Certification:	3 Suicide 6 Could not be	reet, factory, office 28f. Locatio			on (Street and Number or Rural Route Number,							
ā			building, etc. (Specify) City or Town, State)											
			29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du					ue to the cause(s) and manner as stated.					
		edical									tne cause(s)			
	To the hwithin 24	Σ	29b. Signature and title of certifier	29c. License number D 0 0 5 9 7 36 Print)			29d. Date signed (Month, Day, Year)							
	<		· County	- ms		D	0059	736	ma	75	2005			
1	0		30. Name and address of person who co					-	L					
			DEBORATH WATSON 31. Date filed (Month, Day, Year)	32 Banistrar's 9	NORT L	thest 14	OSPITAL	5401	040	COURT	Riado			
F	Sta Registi		MAY n 6	32. Registrar's S	. H.	Ingele								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 6 per th 8844 6-2-05 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year uce 02 Z005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cerr 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Other 24, 1904 Birinplace (State or Foreign Country)
 A 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year **Funeral** Days 12 M-25 F 100 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at Yes 2 No Director Altomore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21224 15.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homenexen Department of Health and Mental Hygivimportant: If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie PARhem GEORGE RYLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUI SE BAITIMUKS MD 2/229 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Bufial 2 ☐ Cremation 3 ☐ Removal from State Woodland CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee AS FUNERAL Home 22. Name and Address of Facility Saturdo Buto 1129 N. CAROTINE ST BANTIMURE AND 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Acure Immediate Cause (Final disease or condition resulting in death) MYOCANDIAL INFACCI Physician /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit Due to (or as a consequence of): attending physician 68760 Physician/Medical as the t Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2∏ No 1 Yes 2 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 217 Other: 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Division Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAY 0 6 2005

repende

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3449 Willers Are #300 Beltimore MO KUNN mo 32. Registrar's Signature

			For State Registrar	State of M		-	tment of F ificate of		and Me						
			Decedent's Name (First, Middle, Last)				2. Date of				of Death 3. Time of Death				
	Physici		VANESSA DENISE CAMPBELL							Month				p:15	- AM
	/Medic Examin														
			GOOD SAMARITIAN HOSPITAL			1	BALTIMORE				N/A				
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs. last bin		If Under 1 Year Months Days	If Under 2	24 Hrs. 8 Min,	Date of Birth (Month, Day,	Vearl	9. E	Sirthpla Countr	ce (State or	Foreign
	Director		213-78-1882	M 2 🛣 F	42	Yrs.	Wioritis Days	Hours		DEC. 22	196	52 N		LAND	
	show		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	n or Lon	tion						10	d Impida Cib	a Limita
											10	10d. Inside City Limits 1X Yes 2 □ No			
	the M	Director	MARYLAND							1.00	- 011-	en of What			
	a or			2012									Countr	y r	
	eath	Funerai	6615 WINDSOR MILL 11. Marital Status	2. Was Decedent	Ever in ITS	13 W	2120 as Decedent of H		nin2 (Speci	fy Ves or No-		B.A. 4. Race - Ar	merica	n Indian	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, Ite Mudical Evantal actional be notified at once.	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces	?	lf.	Yes, specify Cub	an, Mexican	, Puerto Ri	can, etc.)		Black, WI			
93		by	3 X Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Spec					Specify:			S	Specify: E	BLAC	CK	
Õ		Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin							1	6b. Kind	d of Busines	ss/Indu	istry	
21215-0036	thin 7	aldr.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. Do	O NOT use retire	during most d)	t or working						
	er th	Son	12th grade		DAT	'A E	NTRY SPE	CIALIS	ST		DEPI	OFS	OC:	IAL SE	RVICE
nd	al Hy	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (i	First, Middle, M	laiden S	umame)			
<u>×</u>	Ment Ment arkec	To	PAUL EDWARDS SR.					IAM	UDIE 1	MADDEN					
Maryland	2 shoand and Is m		19a. Informant's Name/Relationship (Typ	oe, Print)	19b.	. Mailing	Address (Street	and Numbe	r or Rural F	Route Number,	City or	Town, State	, Zip C	Code)	
	ges 1 and t of Health If item 27 or other tr		Maudie Edwards/Mot	her			Vindsor	Mill 1						-	7
O			20a. Method of Disposition 1XXurial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of cemeter	y, crema	iton (Name or itory or other pla	сө)	Dat	e 2	Uc. Loca	ation - City o	or I ow	n, State	
Baltimore,	t. Pa rtmen rtant:		' 4 □ Donation / 5 □ Other (Specify)		KING M	-	RIAL PAR		05-10					ARYLAN	iD
Ba	Depar Impor		21. Signature of Funeral Service License	-			Name and Addre LLIAM C 06 W NOR			UNITY F	UNEF	RAL HC	ME	P.A.	
	Cate be executed /Medical Examiner the private transit	1	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each i	Iña					espiratory arre	st,			Approximate nterval Betw	
			Immediate Cause (Final disease or condition	EN	D ST	AG	EF	2105					(Onset and D	eath
			resulting in death)	Due to (or as	a consequence	of):	1 0 1	ppris							
			Sequentially list conditions, b	FA.	GE AIDS MLURE										
		Examiner	d any leading to immediate cause. Enter Underlying Cause (Disease or injury	of).											
٧_		хап	that initiated events resulting in death) Last Due to (or as a consequence of):												
68760,															
587		V/Medical	d												
_	eath certif attending for use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								23	23d. Date of delivery			
Вох	at the death certi I by the attending stached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Helal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Month			Day Year		
P.O.		hysi													
	res that igned b	by P								23e. Did toba	pacco use contribute to the cause of death?				
Vital Records,	law require as been sig 2 should b	edt	SEVERE COLITIS							1 🗌 Yes	☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 nknown				
CO		e Completed								24a. Was an		24b. Were	autops	y findings a	vailable
m	The lav									autopsy perform 1 Yes 2		death?	?	oletion of car	use or
ţa	iclan: Th certificate rector, pag		25. Was case referred to medical					26. Place	of Death (Check only one				2 110	
>	Physiclan: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No H	ospital: 1 🛂 inpati	ent 2 ER/Ou	tpatient	3 DOA Oth	ier: 4 □ Nur	rsing Home	5 Resider	ice 6	☐Other (St	ecify)		==
٥	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification; T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju		Time of	28c. Injur Wor	y at		d. Describe hov					
<u>i</u>			2 Accident investigation M 1 Yes 2 No												
Division	r Att	tiff(3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28	28f. Location (Street and Number or Rural Route Number City or Town, State)				er,	
	ital o rs aft al Di														
	e Hosp 24 hou E Fune etely fil	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medicel Examin one)	icien: To the best er: On the basis of and manner s	of examination and	, death o d/or inve	occurred at the tire stigation, in my o	me, date and ppinion, deat	d place, and th occurred	d due to the car at the time, da	use(s) ai te and p	nd manner a lace, and d	as stat ue to ti	ed. ne cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number							29	29d. Date signed (Month, Day, Year)				
			1 Coton Arch mo Boo					016789 MAY 2,				2.	2005.		
	B		30. Name and address of person who col	mpleted cause of	death (Item 23a) (Type, P	rint)								
	1		LORRATINE OFFR	1-HWWH	M, 560,	1 4	3 CH RAV	EN B	LVD	BHLII	maki	= , M	0	2123	9
	Sta Registr		31. Date filed (Month, MAYEA) 6 2	005	luce I	1	market 1								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Francis Custis, Sr. William 9:50 PM APRIL 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Union Memorial Hospital 5. Social Security Number 215-52-4689 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 27, Birthplace (State or Foreign Country) **Funeral** Days XXM 2□F Months Hours Min. Yrs. **Director** 1948 Maryland Nov. 56 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State r than "natural", or itama 23s or 28s-f show the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore Maryland tyE Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 21239 10g. Citizen of What Country? 5027 B The Alameda USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Speci Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hyglene.
7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 2 Home Improvement years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental I permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or othar traumatic evone. Doris mae Custis Elwood Sterling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Custis/ Wife 5027B The alameda Baltimore, Maryland 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/7905 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Greenmount Cemetery Baltimore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Rich 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PCP 9 da /Medical Due to (or as a consequence of): Examiner HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit 0 Due to (1 r as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery jo 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 cartificate has autopsy performed? Yes 22 No 2 No 1 Tes Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) J. 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending Injury 1-Natural 5 Pending after death. | Diractor: Al 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funaral C 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the best of my knowledge, useful occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946-E13 APRIL, 30, 2005 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY PKNY, BALTIMORE MD 21218 SHAHZAD A 201 EAST LICMANI 32. Registrat's Signature rester State MAY 0 6 2005 Registrar

			1 _ State	State of Maryland /		rtment of He			0	0.05		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cert	ilicate of L	eaui	2. Date of Deal	eg. No	UU5.	3 Time of	Death
	Physicia		ROSA C. CHISHOL	m				Month 05 · 02	Day	Year	9:20	A M
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or I	ocation of Dea			ounty of Death	9.20	
		Gı	0.01	4 4	∞	GWYNN	OAK			TIMORE		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last i	birthday)	If Under 1 Year	If Under 24 Hi				ace (State or	Foreign
	Director		244·18·1762 10	M 21 90	Yrs.	Months Days	Hours Mi		14	Coun	"NC	
	DG ≯		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	oum or Loo	otion				1	d. Inside Cit	. I imite
	sho	5								"	1 ☐ Yes	
	Ne M	Director	MD BALTIMOR 10e. Street and Number	E GWYN	710 O	1			0- 04			
	a or			OEN LN. HAI	100	10f. Zip Code 2120	7	'	_	n of What Coun USA	ryr	
	ns 23	Funeral		2. Was Decedent Ever in U.S.			*	Specify Yes or No-		Race - America	n Indian	
"	fter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	lf '	Yes, specify Cuban	, Mexican, Pue	rto Rican, etc.)		Black, White, e	itc.	
036	al', o	by	3 M Widowed 4 □ Divorced	If Yes, Give Year or Dates:	11	□Yes 2KENo	Specify:		S	pecify: BLAC	К	
21215-0036	within 72 hours after deeth with the Maryland ane. than "natural", or Items 23a or 28a-f show ha Medical Examinar must be notified at	Completed	15. Decedent's Educ	cation 16	6a. Decede	ent's Usual Decupat	tion	orking		of Business/Ind		
7	within lene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Di	O NOT use retired)	mig most of th		11166	20- 0	000000	
	be filed within 72 hc tal Hygiene. d other than "natu event, the Medical		9 TH GRADE	NA	SEAM	ISTRESS	40 44-15-1-1		LUGO		MAAMC	ıy
anc		Be	17. Father's Name (First, Middle, Last) DORCOL MARRISON	1			ANNA	ame (First, Middle, 1 GARDNE1		imame)		
Maryland	d 2 should be th and Menta 7 is marked traumatic ev	5	ROBERT MORRISON 19a. Informant's Name/Relationship (Type		Igh Mailing			Rural Route Number		Town State 7in	Codel	
Z	12 s h ar 7 is trau	1 8	CAMILLA MARTIN	_				ELLICOTT	-		,	
ē,	1 a Hea sm sh	3	20a. Method of Disposition	20b. Place	of Disposi	ition (Name of				tion - City or To		
30	® ° = °		1 Surial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State		atory`or other place PRESBY(El	' I .	.01.05	NORT	H CARO	11010	
Baltimore,	_ E E =		21. Signature of Funeral Service License					FUNERAL S			LINE	
m	Depa Impo any ii		2 anon	/	519	SI BAUD. N	JATL PH	KE BALTO	MO	21229		
			23a. Part1. Enter the disease, or complice shock, or heart ailure. List only on	cations that caused the death. D							Approximate Interval Betw	
	Pnysician	g. 13	Immediate Cause (Final disease or condition	Coror		crte		AISCASE			Onset and D	
	/Medical		resulting in death)	Due to (or as a consequent	ce of):		1	7(3 -13	_			
	Examiner		Sequentially list conditions, b.	O Ste	Oart	mitis						
7	pe is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):							
V	be executed ician and burial-transit	каш	that initiated events resulting in death) Last	Due to (or as a consequence		5 7126	es se			-		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transif			C9 -1		Minaman	il our					
687	phys phys s the	dical	d			mon	2) 4 2		red .			
Box (seath certifica attending phate as to	/We	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	,				230	d. Date of delive	v	
ă	death atter	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			20.		,	ear
o.	that the de ed by the detached	hys	9 Unknown	9□ Unknown								
s, P	res that igned to be det	by P	Part II. Dther significant conditions con	tributing to death but not resulting	ng in the und	derlying cause give	n in Part I.	23e. Did tol	acco use	contribute to th	e cause of de	ath?
rd	w require been sig should b							1 □ Y€	s 2 (%)	No 3 ☐ Proba	ıbly 4 ∏Uı	nknown
Record	e law requ has been ge 2 shoul	Completed						24a. Was a		24b. Were autop	sy findings a	ivailable
Ä	The tate has page	E O						perform	ned?	death?		436 01
Vital	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of D	eath (Check only on	-			
of V	0 U	2	1 ☐ Yes 2 No		/Outpatient	3 DOA Other	4 Nursing	Home 5 X Reside	nce 6	Other (Specify)	
		on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28t	b. Time of Injury	28c. Injury Work	?	28d. Describe ho	w injury o	occurred		
Sio	r Attending er death. rector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Olean of lainer. As home			es 2□No	206 Lengtion (Ct		V	D- 4- 4/	
Division		Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, tarm, stre	et, factory, office		28f. Location (St City or Town	reet and r i, State)	Number or Hurai	Houte Numb	er,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1' Certifying Phys	ician: To the best of my knowled	dge, death	Occurred at the time	a, date and nie	ce, and due to the or	ause(s) or	nd manner as et	ated	
	e Hog 24 h e Fur letely	Medical	(Check only 2 Medical Examinone)	ner: On the basis of examination and manner stated.	and/or inve	estigation, in my opi	nion, death oc	curred at the time, d	ate and pl	ace, and due to	the cause(s)	
	To th Mithin To th	Me	29b. Signature and title of certifier)		29c. License	number	2	9d. Date s	signed (Month, L	Day, Year)	
) all			03	0115		574	115		
	1		30. Name and address of person who con	mpleted cause of death (Item 23	Ba) (Type, P	rint)						
	4		T. Ohiokpehsi	, mo 2600 granture 32. Registrar's fignature 2005 flows	L150	esty He	ITS F	He Bal	177	mp 2	1215	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's ignature	ko	hank.	,					
	Regist	rar	MAY	1 6 2005 Bleeve	יאל ע	A DESCRIPTION OF THE PARTY OF T						

			1 - For State Registrar	State of Maryland / Dep	ertificate of L			giene () ()	5 15362
	Physici	an	1. Decedent's Name (First, Middle, La	st)		C.	2. Date of Dea		3. Time of Death
	/Medi		Virginia			Cock	April		06 1730 PM
	Examir	ner	4a. Fecility Name (If not institution, giv	4	4b. City, Town, or	Location of Death		4c. County of	Death
	Funeral		5. Social Security Number 6.5	Sex 7. Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h s). Birthplece (State or Foreign
8	Funeral Director		217-34-6996	1 M 2 M.F (a 7 Yrs.	Months Days	Hours Min.	(Month, Da)	y, Year)	Country) 1ARYLAN
	p ,		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L					
	laryla show	5	M N	3		2 0			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	rect	10e. Street and Number	01	ALTI MOR			10g. Citizen of Wh	
	3a or	Funeral Director		Idin St.	21	224	į	115	A
	deeth	nera	11. Marital Status		. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No	14. Race -	American Indian, White, etc.
36	or its		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No	Specify:	riloan, etc.)	Specify:	white, etc.
5-0036	72 hours after deeth with the Maryland natural', or itams 23a or 28a-f show disal Examiner must be notified at	ed by	3 Widowed 4 Divorced	Year or Dates:					Unite
215	in 72 n "nai	Completed	15. Decedent's E (Specify only highest gra	ade completed) (Giv	edent's Usual Occupa e kind of work done d DO NOT use retired)	luring most of work	ing	16b. Kind of Busi	ness/industry
212	filed within Hygiene. Ither then "ither th	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	ne make	1		athe	inco
	be filed ital Hygi d other svent, I	BeC	17. Father's Name (First, Middle, Last	and the same of th		18. Mother's Nam	e (First, Middle,	Maiden Sumame)	. 0
yla	should be nd Mental marked o	10	Kichard	Jacobs		Virgin	ia Le		reund
Maryland	0 0 2 8		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street a	nd Number or Rur	0		te, Zip Code)
	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr ance.		20a. Method of Disposition	20b. Place of Disp	osition (Name of	INOL,	DALTI	20c. Location - Ci	ty or Town, State
nor	Pages nent of int: If it		1 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	JHemovai from State	ematory or other place		505	Name	MIC
altimore	permit. Pag Department Important: I sny injury o	1	21. Signature of Funeral Service Lice		SSIONALY OO		0-00	11, mo 2	1057
ñ	Depariment Deparement Important Impo	0.0	Kimberly (Baugated F	VAR'S PLAY				war De.
Æ.	ф		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not er one cause on each ima	nter the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Atheroscleroti					Onset and Death
8	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
4		P.	Sequentially list conditions,	b. Due to or as a consequence of					
	uted d ansit	Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events	_		t			
ó	exec en an		resulting in death) Last	Due to (or as a consequence of):					
8760,	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the buriat-transit	Physician/Medical		d					
Ó	entifica ling pl	Med	IF FEMALE:						
Box	attend for us	lan	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of Month	*
	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 5 9□Unknown	Other (specify)				
, P.O.	es thet the death certific: igned by the attending pl be detached for use es t	y Ph	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause give	n in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
rds	equires en sign	q pa	Diabeter Mel	litus Atrial Fi	brillanor	1	1 🗀 Y	′es 2 🗆 No 3	□ Probably 4 ☑ Unknown
000	aw requir as been si 2 should	piete	Chronic obsti	litus Atrial Fi ructure Pulmona	ry Dise	asc	24a. Was	an 24b. We	re autopsy findings available
R	The lay	Completed by			-		autop perfor	rmed? dea	or to completion of cause of th?] Yes = 2 🖾 No
of Vital Records,	ding Physician: The In. After this certificate hat funeral director, page	Be	25. Was case referred to medical examiner?			26. Place of Deat			
€	Physic this c	2	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 ER/Outpatie	The second second	4 🗀 Nursing no		lence 6 Other	
n (Jing F	ion	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work	at ? ′es 2 ⊡No	28d. Describe h	low injury occurred	
Division	Attendii death. ctor: A	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - At home, farm, s					or Rural Route Number,
D	el or / s after il Dire	Certification:	4 Homicide determined	building, etc. (Specify)			City or Tou	m, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical (29a. Certifier 1	nysicien: To the best of my knowledge, dea niner: On the basis of examination and/or i and manner stated.	ith occurred at the time nvestigation, in my op	e, date and place, inion, death occur	and due to the or red at the time, or	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To the vithing To the comp	Me	29b. Signature and title of certifier	V	29c. License			29d. Date signed (i	
	\wedge	N k	* Kaun K	celett, M.D.	D00 5	18676	1	May 2,	2005
	10		30. Name and address of person who	completed cause of death (Item 23a) (Type	, Print)	- Holika az er es	0 0 0 0 0	. A	13 21121
			31 Date filed (Month Day Year)	1 M.D. 25 Main St	ect, suit	6 100	1516	s pwn, i	11136
	Sta Regista		MAY 0 6 20	completed cause of death (Item 23a) (Type 4 M.D. 25 Mc.in 5 to 28. Registrar's Signature	de				

ocnovitch, Joset

or 28a-f show

or Itams 23a

"natural"

1 and 2 should be filed within Health and Mantal Hygiene. em 27 Is marked other then '

of Health a

other traumatic event, the Medical Examiner must be notified at

1 - For State Registrar

Decedent's Name (First, Middle, Last)

Physician 2005 Joseph Alonzo Cocnavitch /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner Hospita rosego Parklin 0 Sq-har If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1□M 2□F Days Min 215 07 4981 March 16 1919 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31. Hapsburg Court Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ☐Yes 2 XNo Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 M Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/Α Postal Clerk US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Cocnavitch Elizabeth Dora Bothe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul E Cocnavitch 31 Harsburg Court Baltimore Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. May 4 2005 Baltimore, Maryland 21. Sig. twe of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home, Inc. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. 23a. Part1. Enter the disease, shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Cordiovascular Prosc if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Examiner Completed by Physician/Medical Examiner burial-transit Box 68760, Division of Vital Records, P.O. To the Hospital or Attending Physician: Be 은 this After (Certification: after death. ecto: by within 24 hours aft To the Funaral Di Medical

9 Unknown	9 Unknown	
Part II. Other significant condi	tions contributing to death but ngt resulting in the underlying cause given in Part I. b structive lung Piseose	23e. Did tobacc
Periphera Hyperten	Vascular Disease	24a. Was an autopsy performed?
25. Was case referred to medic	cal 26. Place of Dea	th (Check only one)

23e. Did tobac	co use con	tribute to the cau	ise of death?
1 Yes	2 🗆 No	3 Probably	4 Unknov

Month

	1 Yes	2 🗆 No	3 Probably	4 Unknown
04-	146	0.45	Minne - America C	

Day

Year

a. Was a autops	prior to completion of cause of
7	4 C V 2 C V

Hospital: 1 ☐ Inpatient 2 Z ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No

	1□ Yes	2Z No	1 Yes	2□ No	
of Death (0	Check only	one)			

Reg. No.

2. Date of Death

3. Time of Death

0

Birthplace (State or Foreign Country)

Baltimore, Maryland

Black, White, etc.

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 6 Could not be determined

Ouron.	4 Nursing F	lome	5 Residence	6 ☐Other (Specify)
njury at Work?		28d.	Describe how inju	ary occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. l

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

27. Manner of Death

1 Natural 2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)
in Sheridan 9000 Franklin Square Name and address Mortin

31. Date filed (Month, Day, Year)

State Registrar

10

MAY 0 6 2005

		•	For State	State of Marylar		ent of Health and ate of Death		2000	15001
	*	. 6	Registrar 1. Decedent's Name (First, Middle, La	st)	Octuno	ite of Death	Reg 2. Date of Death	. No U U ()	3. Time of Death
	Physici /Medic		a leve 1	A Clevelan	1)		Month	Day Year 2005	2:52 AM
	Examin		4a. Facility Name (If not institution, giv	e street and number)	4b. Cit	ty, Town, or Location of Dea		4c. County of Death	~
			FRANKLIN SQUAR			ROSEDALE		BALTIM	ORE
- 0	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	Ast birthday) If Und	der 1 Year If Under 24 Hrs is Days Hours Min		(ear) 9. Birthpl	lace (State or Foreign try)
	Director		2-04 -03 -93/8 Usual Residence of Decedent		70		Mpr1/5,	1913 F10	RI do-
	nyland how		10a. State 10b. County		ty, Town or Location			10	Od. Inside City Limits
	e Ma	ctor	MD		Baltinor	2			1 Yes 2 No
	vith th	Director	10e. Street and Number	/ 2	10f. 2	Zip Code	10g	. Citizen of What Coun	try?
	s 23e			11wood AV	e. 12 W- D-	21224		U.S.F	<u> </u>
10	fter d	Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	If Yes, s	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	rto Rican, etc.)	14. Race - America Black, White, 6	
33	72 hours after death with the Maryland natural, or Itams 23a or 28a-f show Ital Examinational Lemoiffed et	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: /////	7∠ 1□ Yes	2 No Specify:		Specify: W	hite
ムモvモ 215-0036	72 hc natur	Completed by	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Us	sual Occupation work done during most of wo use retired)	orkina 16	b. Kind of Business/Inc	lustry
75	within ene. than "	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)				.1 /	1 - 0
ر م ط21	Hygie Hygie other	ပိ	17. Father's Name (First, Middle, Last)	Electi		MCC/K ame (First, Middle, Ma	ICS FING	house
ELAND Maryland	lid be lental kad c	To Be	Mere H.	Cleveland		Ten	11 616.	taken	
aryla	should I		19a. Informant's Name/Relationship (19b. Mailing Addre	ss (Street and Number or F	Rural Route Number, C	City or Town, State, Zip	Code)
232	and 2 ealth n 27 i		Thelma Clevelo	wo -wife	255	5. Ellwoo	d Ave I	Ballo, m.	121224
CLEV	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Medical Exertment intel be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		Place of Disposition (Nonethery, crematory of	lame of r other place)	Date 20	c. Location - City or To	wn, State
3 ≣ 5	permit. Page Department o Important: If any injury or once.		*4 ☐ Donation 5 ☐ Other (Special	y) Da	yview Cr		6/05	Kaltimon.	2
Bal	permit. Departr Importa any inje		21. Signature of Funeral Service Lice	1500	Bra.	and Address of Facility	4 FUNCRA	I Nome,	P.A.
100			23a. Part 1. Enter the disease, or com	plications that caused the deal	th. Do not enter the m		SACING K		Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		, ,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. PHEUMON Due to (or as a consec					
	Examiner		Sequentially list conditions,	b					
jd	be sit	Examiner	if any, leading to immediate cause. Erner underlying Cause (Disease or injury	Due to (or as a consec	juence of):				
/	executed n and ial-transit	хап	that initiated events resulting in death) Last	c	luence of):				
8760	icate be executed physicien and s the burial-transit	dical		d	, , .				
9		0		· ·					
Вох	death certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 Live birth 2 Feta	ancy al death 3 □Ectopic	pregnancy		23d. Date of deliver	,
E	es that the death igned by the atte be detached for	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o		specify)		Month	Day Year
P.(hat th ad by detacl	Ph)	Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	ranco anon in Bort I	22a Did tehan	co use contribute to the	aguag of death?
Division of Vital Records, P.O.	signé d be			or indicate and the first for the first	and an and an and any and	y cause given in Fait i.		2 ☐ No 3 ☐ Proba	
200	w requir been si should	lete				·	24a. Was an		sy findings available
Re	ilcian: The lav certificate has rector, page 2	Completed					autopsy performe	prior to com	pletion of cause of
ita	ian: rtifica stor, p	BeC	25. Was case referred to medical			26. Place of De	ath (Check only one)	No 1 ☐ Yes	2 No
> _	hysic his ce I direc	ToE	examiner? 1 □ Yes 2 No	Hospital: 1 X Inpatient 2 □	ER/Outpatient 3 0	04		e 6 Other (Specify,	
٥	ding Physician: The I h. After this certificate ha funeral director, page		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
<u>s</u>	ttand death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not b		М	1 Yes 2 No	2011		_
Di∨	after Dirac	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	ome, farm, street, factors)	ory, office	City or Town, S	et and Number or Rural State)	Houte Number,
	To the Hospitel or Attanding Physician: The law requires that the death certif within 24 hours after death. To tha Funaral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use a		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, death occurre	ed at the time, date and place	e, and due to the caus	se(s) and manner as sta	ıted.
	the Hi in 24 tha Fu	Medical	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.	ition and/or investigation	on, in my opinion, death occ	urred at the time, date	and place, and due to	the cause(s)
	with To 1	Σ	29b. Signature and title of certifier	0010	1 11 1	9c. License number	29d.	Date signed (Month, D	ay, Year)
	/		- CMW			RES 0000		> 15/05	
	5		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, Print)	HARE DRIVE	RAITIME	EMAD	1237
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra Signa) 6 2005	ature .	WARE DRIVE;	12TO I IPTUR	~ , 100	>/
3 - 3	Registr	Α	MAY () 6 2005 Block	w to the	and a			

			For State		State of	Maryland		artment of rtificate o			lental H		Em W W C	15365
			Registrar 1. Decedent's Name (First	st, Middle, Las	·)			inoate e	Dout		2. Date of D			3. Time of Death
	Physici /Medio		DO	RIS			C	OHEN			MAY 3	, 200)5 Yea	9:40 A M
)	Examin		4a. Facility Name (If not i					4b. City, Town	, or Location	of Death		40	. County of De	ath
			HOSPICE OF 5. Social Security Number			CHRIST		If Under 1 Ye		WSON 24 Hrs.	O Data of D	l'at-		TIMORE
	Funeral Director		093-10-17	4.5	_M 202 F	88	Yrs.	Months Day		Min.	8. Date of B (Month, I MAY 3	9ay, Year)	7	irthplace (State or Foreign Country) NY
			Usual Residence of Dece	edent							117(1 0	, 13.		,
	anylan ehow	'n		County	MODE	10c. City	Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	289-f	Director	MD 10e, Street and Number	BALTI	MUKE		BALI	I MORE	Α			10a. Ci	tizen of What (
	h with	ai D	25 EMERAL	D RIDGE	COURT				212	09				USA
	ems a	Funerai	11. Marital Status		12. Was Deced	dent Ever in U.S ces?	S. 13.	Was Decedent of If Yes, specify C	of Hispanic Or uban, Mexica	rigin? (Spe	ecify Yes or N	10-	14. Race - An Black, Wh	nerican Indian,
36	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show dical Evarrimer must be notified at	by FL	1 ☐ Never Married : 3 🕅 Widowed 4 ☐ I		1 □Yes : If Yes, Give Year or Da	•		1 □ Y <i>e</i> s 2 💢 i					Specify:	
21215-0036	2 hour	ted t	15. [Decedent's Edi	ucation	185.	16a. Dece	dent's Usual Oc	cupation			16b. K	(ind of Busines	WHITE
215	within 73 ene. than "n	Completed		nly highest grad (0-12)	de completed) College (1-	4or 5+)	lite.	kind of work do DO NOT use rel	ne during mo: ired)	st of work	ing			,
	filed withi Hygiene. rther than	Con	Elementary/Secondary				HOME	MAKER					HOME	
Maryland	d ta b	Be.	17. Father's Name (First,	, Middle, Last)			BERL	ΔΝΠ	IDA	ers Name	e (First, Midd	ie, Maider		IBOWITZ
aryl	2 should and Men Is marke sumatic	L _o	19a. Informant's Name/F	Relationship (T	ype, Print)			ng Address (Stre		er or Rura	i Route Num	ber, City		
	1 and 2 Health a lem 27 ls		JUDY STEL	LMAN /	DAUGHTE	ER	25 E	MERALD	RIDGE	COUR	т – ВА	LTIMO	DRE, MD	21209
ore	Pages 1 and of He		20a. Method of Disposition		Removal from S		ace of Dispo metery, crei	sition (Name of natory or other p	olace) PAR	K	ate	20c. L	ocation - City o	or Town, State
Baltimore,	t. Pag rtment rtent: njury o		`4 ☐Donation 5 ☐	Other (Specify)	OHE		OM MEMO			5/2005			OWN, MD
Bal	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other 2005e.	i ja	21. Signature of Juneral	Service Licens	Cutt	2		2. Name and Ad 900 REI		301				., INC. , MD 21208
			23a. Part1. Enter the dis shock, or heart faile	ure. List only o	lications that ca ne cause on ea	used the death ich line.	. Do not ent	er the mode of o	tying, such as	cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a. Mc	, Ct. P	ole c	NgAn	.tAi	(01	2			weeks
	Examiner				Due to (c	or as a constitu	ence of):	a co	<	0115	ic			1,00000
		ner	Sequentially list condition if any, leading to immediately cause. Enter Underlying	iaie III	b. Due to (c	or às a consequ	anca off.	H CU				-		Wars
4	ecuted and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c.									
60,	ficate be executed physician and is the burial-transit	ai E)	robating in dodiny Edot	- 1	Due to (d	or as a consequ	ence or):							
68760,	ficate physics the	edicai			d.									1
Вох	eath certific attending pl	M/us	IF FEMALE: 23b. Was decedent preg	gnant	23c. If yes, outc	ome of pregnar		Ectopic pregna	ncv				23d. Date of d	
P.O. E	the the	Physician/M	in the past 12 mont 1 ☐ Yes 2 No 9 ☐ Unknown	ins?		int at time of de		Other (specify,					Month	Day Year
	res that the signed by be detact	by Ph	Part II. Other significant					nderlying cause	given in Part	1.	23e. Did	tobacco	use contribute	to the cause of death?
rds	w require: been sign should be	ed b	galls	Hone	panor	extiti	<u>"5</u>				1 🗆	Yes 2	X N0 3□1	Probably 4 Unknown
Records,	e law re has beo	Completed	U								24a. Wa	s an opsy	24b. Were a	autopsy findings available completion of cause of
E		Con										formed?	death?	s 2□No
Vital	Physician: The raths certificate ral director, pag	Be	25. Was case referred to examiner?	-	Hospital:				Other		(Check only			77
of	ding Physician: h. After this certific funeral director,	5	1 ☐ Yes 2 No 27. Manner of Death	5.5	28a. Date of	f Injury	ER/Outpatier 28b. Time of	1 3 DOA	ijury at Vork?		me 5 Res 28d. Describe		6 Other (Sp ry occurred	ecify) (-05/102
ion	nding ath. r: Afte	ation	1 XNatural 5 [2 ☐ Accident	Pending investigation	(Month	n, Day Year)	Injury		Vork? □Yes 2□	No				
Division	r Attencter death	Certification:	3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined	28e. Place o	of Injury - At hor g, etc. (Specify)	me, farm, str	eet, factory, offic	СВ		28f. Location City or To	(Street ar	nd Number or F	Rural Route Number,
	pitel o			0 171 0	<u> </u>									
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the fune	Medicai	29a. Certifier 1 (Check only 2 one)	Medical Exam	rsicien: To the liner: On the base and manner	sis of examinati	viedge, deati ion and/or in	occurred at the vestigation, in m	y opinion, dea	nd place, a	and due to the	e cause(s e, date and) and manner a d place, and du	as stated. ue to the cause(s)
	Vith To t	Σ	29b. Signature and title of	of certifier	1	le.	un		ense number	1				2005
•	3		30. Name and address of	of person who o	ompleted cause		23a) (Type,	Print)	00 (7 6	200 P.A.	121	1 2/2	2005
	Sta	te	31. Date filed (Month, Da		32. Re	gistrar's Signat		· Our	ر وما		40,	1010	, -/	
	Registr	_	MAY 0 6	2005	Signal	· K	South	,						

05.03. 2005

Please Type or Print in Black Indelible Ink. I	Ensure All Copies Are Legible.
--	--------------------------------

			For State Registrer	State	of Marylan	-	artment of H tificate of L			giene	5	15366
	Dhusisi		1. Decedent's Name (First, Middle	, Last)		-			2. Date of Dea	ath _	Year	3. Time of Death
	Physici - /Medic		MORGAN		OSWELL				05	04 2	005	4:50 PM
	Examin	er	4a. Facility Name (If not institution	-			4b. City, Town, or			4c. County of	of Death	
			6 00D SAMARIT 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday	D 17 L I If Under 1 Year	If Under 24 Hr		N/		
	Funeral Director		224-22-4966	1 XX M 2□ F	7. Age (in yrs. i		Months Days	Hours Mir		v, Year)	Coun	
			Usual Residence of Decedent						July 2	1916	VIR	GINIA
	nylan how	L	10a. State 10b. County		10c. City	y, Town or Lo	cation				10	Od. Inside City Limits
	Ba-f s	Director	VIRGINIA			BLA	CKSTONE					Y Yes 2 □ No
	vith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Coun	try?
	s 23g	rai	1195 STINGY			0 1.0	2382			U.S.		
	Item	Funerai	11. Marital Status 1 ☐ Never Married XMarr	Armed F	edent Ever in U. orces? 2 \(\sum \text{No} \)		Vas Decedent of His Yes, specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes or No- into Rican, etc.)		- America , White, e	
3	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	V0 40 /	46	☐ Yes 2X No	Specify:		Specify:	BLA	ACK
Ş	be filed within 72 hours after death with the Maryland ttal Hygiene. dd other than "natural", or items 23a or 28a-f show avant, I's McJical Extra ill aff-stall be indiffed at	Completed	15. Decedent			16a. Deced	ent's Usual Occupa	tion	- 1:	16b. Kind of Bus	iness/Ind	ustry
21215-0036	Ban "r	npie	(Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	life. L	kind of work done d OO NOT use retired)	uring most of w	orking			
	filed w Hygier Ather th		12th grade	l yr		PRE	SSOR					RING CO.
Maryland	ild be fil lental H ked ott ic avan	Be	17. Father's Name (First, Middle,	,					ame (First, Middle,	Maiden Sumame)	
$\frac{3}{2}$	should nd Men marke umatic	ပ္	WILLIAM DOSWE 19a. Informant's Name/Relationsl			10h Mailia	- Add (C44-		MORGAN	0. 7		
<u>≅</u>	d 2 shoth and the and traum		Barry Doswell/	, , , , , ,			g Address (Street a					
ē,	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		20a. Method of Disposition	5011	20b. P	ace of Dispos	Harness		Williamsr Date	20c. Location - C		
ê	Pagas nent of int: If it		MXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	•	natory or other place	· !	F 10 0F	DI AGRAM		
altimore,	permit. Pagas 1 Department of H Important: If ite any injury or ott		21. Signature of Funeral Service			22	AMILY CEM Name and Address	s of Facility	_	BLACKST	- 7	
n	B I D B	. 1	1300	-		W1	lliam C B 206 W NOR	ROWN CO. TH AVEN	MMUNITY F UE	FUNERAL I	HOME	P.A.
			23a Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death					rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a .	SEPS15						2	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ							cargo
	LAGIIIIIO	er	Sequentially list conditions, if any, leading to immediate	b. ————	LUNG (or as a consequ		ESS				2	days
7	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to	PNEU	,	A				1	· · · a a la
	arecu n and al-tra	Examine	that initiated events resulting in death) Last	c	(or as a consequ		71					- WEEK
2/8 2/8	ficate be executed physician and s the burial-transit	cai		d								
0	rtificat ng phy as th	edi	IS SENAN S									
X Q Q	death certifi e attending id for use as	ician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnal		Ectopic pregnancy			23d. Date		
5	w requires that the death certifi been signed by the attending t should be detached for use as	sici	in the past 12 months? 1 □ Yes = 2 □ No 9 □ Unknown		nant at time of de		Other (specify)			Mont	h [Day Year
J.	d by detack	Physi	Part II. Other significant condition	ne contributing to d	ooth but not soou	diamin the co	dash isan sanas an	- in One I	one Didtel	haaa		
g,	requires that the een signed by th nould be detache	l by	CHRONIC DIC	_			HYPERT			bacco use contrib es 2 No 3		bly 4 Unknown
Ö	requ	etec	CHICITIE PIE)	ried Con		DIFFE	Elegio	+			
Hecords,	has has	Completed							24a. Was a autops perfor	in 24b. We sy pri	ere autop: or to com ath?	sy findings available pletion of cause of
-	vician: Th certificate rector, pag	CC	25. Was case referred to medical					00 81	1 ☐ Yes	21 No 1	Yes 2	₽ No
>	Physician: this certific ral director,	OB	examiner?	Hospital:	 Inpatient 2□E	ER/Outpatient	Otho		ath (Check only on Home 5 Reside		(Case h)	
1 O I	g Phy ter thi	n: T	27. Manner of Death	28a. Date		28b. Time of	28c. Injury Work			ow injury occurred		
Š	andin lath. or: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation	in, Day rear)	Injury		es 2 🗆 No				
UNISION	ter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At hor	me, farm, stre	et, factory, office		28f. Location (St City or Town	treet and Number n, State)	or Rural	Route Number,
	pital o											
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Xaminer: On the b	best of my knov asis of examinati ner stated.	vledge, death ion and/or inv	occurred at the time estigation, in my opi	e, date and plac nion, death occ	e, and due to the ca urred at the time, d	ause(s) and m <mark>a</mark> nr ate and place, an	ner as sta d due to t	ted. he cause(s)
	othin vithin o the	Me	29b. Signature and title of certifier	andman	ner stated.		29c. License	number	2	9d. Date signed (Month, D	ay, Year)
	->-0		Honnit	eum	M.D.		RES	- 000		05/0	410	5
	121		30. Name and address of person v				nnt)			/ -	//	
	Ce'		SOMNATH GHO					BALI	-IMORE	MD 9	2123	9
	Sta	_	31. Date filed (Month, Day, Year)	2005	egistrar's Signat	ure	- di -					
	Registra	al.	MAY 0 6	2000	en s	A A SO						

				Please	Type or Pri									
			For State		State of M	arylan			Health and I	Mental Hy	/gien	0005	1 200	000
			1 - State Registrar 1. Decedent's Name	e (First Middle Las	st)		Cel	rtificate of	Death	2. Date of De	Reg. No	000	1 Ö	of Death
	Physici			Marie	•					Month May 4	Da	^{ту}		
	/Medio Examir		4a. Facility Name (I	f not institution, give	street and number)			4b. City, Town,	or Location of Death			. County of De		.U A
				ist Cen				Towso			В	altimo		
	Funeral Director		5. Social Security N 215-42-9	1	⊓м х/т м=		last birthday) Yrs.	If Under 1 Year Months Days		(Month, D	ay, Year,		irthplace (Star Country)	
			Usual Residence of			93				Dec.5	, 191	_I Ma	rylan	d
	anylan show	_	10a. State	10b. County			y, Town or Lo							City Limits
	he Ma	Director	MD 10e. Street and Nur	Baltir	nore	Ow	ings							es XXNo
	with la or 3				Forest	ъд		10f. Zip Code	1117		10g. Ci	tizen of What (•	
	death ms 23	Funerai	11. Marital Status	allison	12. Was Decedent	Ever in U.	S. 13. V		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No	0-	14. Race - An		
٥	after or Ite	Fur		ed 2 Married	Armed Forces? 1 ☐ Yes 200 If Yes, Give			fYes, specify Cub I□Yes **(T No		o Rican, etc.)		Black, Wh	nite, etc.	
9500-6121	be filed within 72 hours after death with the Maryland all Hygiene. de other than "natural", or items 23e or 28esf show other than "natural", or items 23e or 28esf show event, the Medical Exartinal must be notified at	d by	3XXWidowed		Year or Dates:								White	
γ	in 72 in 72 in 12	Completed		15. Decedent's Ed	de completed)		(Give	tent's Usual Occu kind of work done DO NOT use retire	during most of wor	king	16b. K	(ind of Busines	s/Industry	
717	e filed withial Hygiene.	omo	Elementary/Seco	ndary (0-12)	College (1-4or	5+)	Nanr		,		P	rivate	Home	<u>:</u>
and 2	e filed al Hygia f other vent, I	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle	, Maider	Sumame)		
<u> </u>	Ment Ment arkec	To		W. Wil						Wetze				
Mar	es 1 and 2 should be f of Health and Mental H f Item 27 Is marked of ir other traumatic ever		19a. Informant's Na		^{Гурв, Print)} Daughte				and Number or Ru					
o,	1 and Healt lem 2		20a. Method of Disp		Daugnice		_	Sition (Name of natory or other pla	rter Rd.	Date		ocation - City of		
Baltimore,	Pages nent of h ant: If Ite ury or of		XX8urial 2		Removal from State					E /7 /0E		_		
<u>=</u>	permit. Page Department of Important; If any injury or once.		21. Signature			Eve	22	. Name and Addre	ardens :	khardt	Fun	eral (hanel	P.A.
<u>n</u>	89588		The	lovor	france				stersto					
			shock, or hear	rt failure. List only	olications that caused one cause on each li	the deathne.	. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	ırrest,		Approxim Interval E Onset an	nate Between
	Pnysician /Medical		Immediate Cause (disease or condition resulting in death)		a. Lyv	npk	oma						Uestan	
	Examiner			ſ	Due to (*r as	a consequ	uence of):							
Ŀ		Jer	Sequentially list cor if any, leading to im cause. Enter Under	nditions, mediate	b. Due to (or as	a consequ	uence of):							
	executed in and ial-transit	Examine	that initiated events	injury.	c									
Ď,	be exe icien a burial-	_	resulting in death) L	.451	Due to (or as	a consequ	uence of):							
280	eath certificate be executed attending physicien and for use as the burial-transit	hysician/Medical			d	_							-	
×	nding use a	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of pregna						23d. Date of de	elivery	
מ	death	icia	in the past 121	months?	1☐Live birth 4☐Pregnant at			Ectopic pregnanc Other (specify) _	у			Month	Day	Year
r S	that the ed by th detache	Phys	9 🗆 Unknown	V	9□ Unknown									
		þ	Part II. Other signifi	cant conditions co	ontributing to death b	ut not rest	ılting in the un	iderlying cause giv	ven in Part I.			use contribute		
coras	requires been sign should be	etec								10		<u> </u>		Unknown
d)	B 25 B	Completed								24a. Was autop perfo	psy	prior to	utopsy finding completion of	s available cause of
	iician: Th certificate rector, paç	a)	25. Was case referr	ed to medical					26. Place of Deal		2 X No	1 ☐ Ye	s 2 No	
	Physician: this certific ral director,	To B	examiner? 1 □ Yes 2 1	1	Hospital: 1 🗆 Inpatie	ent 2 🗆	ER/Outpatient	3 DOA Ott	1er: 4 Nursing H			6 Ve ther (Spe	ecity) Nov	rico
0	ding Ph .r After th funeral		27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. Inju	ry at	28d. Describe I	how injur	y occurred		14
<u>S</u>	tendi death. tor: A the fu	cati	2 ☐ Accident 3 ☐ Suicide	investigation					Yes 2 □ No		_			
DIVISION	or Al after of Direction by	Certification:	4 Homicide	determined	28e. Place of Injuding, etc	ury - At ho c. <i>(Specif</i> y	me, farm, stre	et, factory, office		28f. Location (S City or Tox	Street an wn, State	d Number or F)	Rural Route Nu	mber,
	To the Hospital or Attending Physician: The inwitin 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier	Certifying Phy	vsician: To the best	of my know	wledge, death	occurred at the ti	me, date and place.	and due to the	cause(s)	and manner a	s stated	
	n 24 h	edical	(Check only one)	2 Medical Exam	iner: On the basis of and manner sta	examinat	ion and/or inv	estigation, in my o	ppinion, death occur	red at the time,	date and	place, and du	e to the cause	(s)
	To the To the company	Σ	29b. Signature and		n			29c. Licens				te signed (Mon		
	4		AK	ran	Luns			DS	8303		MA	74	Sool	7
	b				ompleted cause of d	eath (Item	23a) (Type F	rint) On	mer Si	- Kau	no	re nr.	21204	/
	Sta Registr		31. Date filed (Mont	MAY 0 6 2	005 32. legistra	ar's Signat	to Ap	and a						

			1 - For State Registrar	State of Maryland		rtment of Hotilicate of L			Reg. No.	2005-	15368
	Physici /Medio		1. Decedent's Name (First, Middle, La Toseph	Dukes				2. Date of De	Day.	2005	3: Time of Death
}	Examir			ospital		4b. City, Town, or Randal	Istow	1	B	ounty of Death	re
	Funeral Director		,	Sex 7. Age (In yrs. las 1 MZ M 2 □ F 59	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	1945	9. Birthp Coun	lace (State or Foreign try)
	Maryland I-f show	tor	10a. State 10b. County		Town or Loc	_				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 3s or 28s	Funeral Director	10e. Street and Number 1322 MERIDENE	DRIVE		10f. Zip Code 21239			10g. Citize	en of What Coun	itry?
920	poemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Iem 27 is marked other then "natural", or Items 23a or 28a-f show mith injury or other treumatic event, I'm Medical Francia ermust be notified at ance.	by	11. Marital Status 1 (MS) Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:	1	/as Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)		Race - Americ Black, White, C Cpecify: BLAC	etc.
21215-0036	filed within 72 ho Hygiene. kther then "natur ant, the Me Jicell	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Gi ve k life. D	ent's Usual Occupa kind of work done di O NOT use retired)	tion uring most of wo			of Business/Ind	,
Maryland 2	2 should be filed and Mental Hyg Is marked other sumatic svent,	To Be C	17. Father's Name (First, Middle, Las. IHOMAS DUKES	,)			MARY B	ne (First, Middle, RAXTON	Maiden S	umame)	
	1 and 2 st Health and em 27 is n		99a. Informant's Name/Relationship SHARON DUKES 20a. Method of Disposition		322	Address (Street a. MERIDEN ition (Name of		_	mo	21239	-
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Service Lice)	Removal from State GARF	etery, crem 3180N	atory or other place FOREST	05.1	0.05	DIMO	ation - City or To GS MIU	
Ba	Depa Impo		23a. Part1. Enterple disease, or con	4	515	Name and Address JOHN C. G BALTO. N	JATL PIK	E, BALTO.	MID	21229	Approximate
	Physician /Medical Examiner	ier	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if ny learning immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequent of the consequent	nce of):	y farchis	20				Interval Between Onset and Death
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	nce of):						
.O. Box 6	it the death certific by the attending p tached for use as is	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	ath 3 1	Ectopic pregnancy Other (specify)			23	d. Date of delive Month	ry Day Year
rds, P	w requires that been signed be should be det	by	Part II. Other significant conditions	contributing to death but not resulting	ng in the un	derlying cause give	n in Part I.	23e. Did ti	-		e cause of death?
		Completed						24a. Was autor perfo 1 X Yes		prior to con death?	osy findings available appletion of cause of 2 \square
Vital	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:		3C DOA Other		ath (Check only o			
of	After After fune	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Outpatient Bb. Time of Injury	28c. Injury Work	4 La Huraning I	ome 5 Residence Residence Page 1			·)
Division	spitel or Attendi ours after death. lerel Director: A filled in by the f.	Certification;	3 Suicide 6 Could not to determined	De Cas Blace of Injury. At home	a, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and I vn. State)	Number or Rural	Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysicien: To the best of my knowle miner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time estigation, in my opi	e, date and place nion, death occu	, and due to the rred at the time,	cause(s) ar date and p	nd manner as sta lace, and due to	ated. the cause(s)
	To t To ti	M	29b. Signature and title of certifier Pebrah B	elchis, MD		29c. License				signed (Month, E	
	5		Deborah Belchis	completed cause of death (Item 23) North west He	ospito	Print) 5401	old Cou	t Road	Rand	lallstou	in Haryland
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's gnature	a A	Boarde					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death)

42	1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygier	1000 10000
Physician /Medical	1. Decedent's Name (First, Middle, Last,	10:2		2. Date of Death Month	Day Year 3. Time of Death
Examiner	4a. Facility Name (If not institution, give Balt. moz. Rehabilitation	street and number) not Extended Conne Centre		h	4c. County of Dealh
Funeral Director	5. Social Security Number 6. Sec. 15 46 882-3	7. Age (In yrs. last birthday) M 2□ F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Monihs Days Hours Min		9. Birthplace (State or Foreign Country)
Maryland I-f show	10a. State 10b. County	BALLIMO			10d. Inside City Limits 10d. Yes 2 □ No
ufer death with the Maryland r flems 23s or 28s-f show it will refer in titlish at Funeral Director	10e. Street and Number 2837 & Hills.	ed St	10f. Zip Code 3 1313	10g.	Citizen of What Country?
or ite	11. Marital Status 1	1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
n 72 hc	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	e completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b.	Specify: BIACK. Kind of Business/Industry
be filed within tal Hygiene." d other then " event, I a Mer	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) C/EA	wed	-	(lenning)
should be not Ments a marked umatic e	19a. Informant's Name/Relationship (Ty	// S pe, Print) 19b. Mailie	Johnny ng Address (Street and Number or R	MAE =	Y or Town, State, Zip Code)
	Shenila Mover-fac. 20a. Method of Disposition	20b. Place of Disponerary, cremetery, crem	Siles Course sition (Name of matory or other place)	But moze & P. Date 20c.	1D 2/23/ Location - City or Town, State
permit. Page Department o Importent: If any injury or once.	1 ☐ Buria 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Connection State	1 1	5/05 I	Portmere MD.
Pe G I I I I I I I I I I I I I I I I I I	23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the death. Do not ent	er the mode of dying, such as cardia		Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	INCCT		Month 5
flicate be executed physician and is the burial-transit edical Examiner	Sequentially list conditions, I ary, reading to minior action of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
death certified attending at for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
igne igne be d	Part II. Other significant conditions con	stributing to death but not resulting in the u	nderlying cause given in Part I.		ouse contribute to the cause of death? 2 No Probably 4 Unknown
The gate has page				24a. Was an autopsy performed?	
certifi rector	25. Was case referred to medical examiner? 1 Yes No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Othor	ath <i>(Check only one)</i> Home 5 ☐ Residence	6 ☐Other (Specify)
fter free	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in	
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After completely filled in by the funeral Completely filled in Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
ithin 24 hour the Funer or the Funer ompletely fil	29a. Certifier Certifying Phy. (Check only 2 Medical Exami	sician: To the best of my knowledge, death ner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occurrence	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the to the comp	29b. Signature and title of certifier	Le Marian	29c. License number		Date signed (Month, Day, Year)
Ý	; L] 13	mpleted cause of death (Item 23a) (Type.	D. Doc550: aven Bld, Bat) AD	10 21218
* State	3T. Date filed (Month, Day, Year)	22. Registrar's Signature	aven bla, bat	ima, in	10 61615

Markus Wilson Felder Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03085 State of Maryland / Department of Health and Mental Hygiene RJ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** MARKUS UI. FELDER 2005 /Medical a. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5970 Washington Boulevard (Route 5. Social Security Number 6. Sex 7. Age (In yrs. Jas Flkridge
If Under 1 YeaP If Under 24 Hrs. 8. Date of Birth
(Month, Day, Howard County 9. Birthplace (State or Foreign **Funeral** Months 18 M 2□F 220 · 15 · 9380
Usual Residence of Decedent Yrs. MD 07.01. Director 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show the Musical Examiner; sust be notified at 1 X Yes 2 □ No NIA MD BALTIMORE Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö SIREET W. BALTIMORE 21223 USA Itams 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN DEMOCRATIC CLUB 11/H GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fi and Mental H is markad ot AREATHER JENKINS WOODROW FELDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traum ST., BALTO. MO 21223 AREATHER JENKINS 2564 W. BALTO. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ZION 05.09.05 BALTO, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE aner 5151 BALTO. NATU PIKE BALTO. MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gunshot Wounds (2) of Head and Hand **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): 68760. that the death certificate be Physician/Medical use as t Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 1 Yes 2 No 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ pe 2 D No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 No 24a. Was an 1 XYes 2 No Division of Vital tha Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Cther: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) At SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1

Yes 2 □ No this uneral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending Shot 1 ☐ Yes 2 No subject investigation 4105 12:22 after death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Freet and Number or Rural Route Number City or Town, State) -970 Was Kington B filled in by 4 Homicide washington BlVd EIKVING Laca within 24 hours a To tha Funaral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Medical

D State

completely

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 Verse

29c. License number OCME

29d. Date signed (Month, Day, Year)

May 4, 2005

111 Penn Street Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 4:20a™ Lemuel B. Fowler May 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Ivy Hall Nursing Center Middle River If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1**√2** M 2 ☐ F Yrs. 241-10-0191 94 Sept. 7, 1910 North Carolina Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show in then "natural", or iteme 23a or 28a-1 show the Medical Examiner must be notified at MD Baltimore Middle River 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1500 Aldeney Ave. 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene.
7 is marked other then "ne Mark Trace Elementary/Secondary (0-12) College (1-4or 5+) Maintence 7th permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumer. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James L. Fowler Elizabeth Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Fowler /wife 1500 Aldeney Ave. Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MeadowridgeCemetery 5/6/05 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licens 300 Mace Ave. Baltimore MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused to Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate has been signed by the attending physician and nector, page 2 should be detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending To the needs after death, within 24 hours after death.

To the Funeral Director: After the funeral by the funer 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel or 29a. Certifier I 🖟 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number State Registrar

			1 - For State Registrar	State of				t of H	ealth a		lental H	ygien Reg. N	000		153	72
	Physici /Medic	al	Decedent's Name (First, Middle ZAME	-			FRE1				2. Date of D Month April	30, ^D		Year	3. Time of 5:094	
	Examin	er	4a. Facility Name (If not institution						Location				c. County o			
			Washington Adve		oital . Age (In yrs.	last hirthday	Tal		Park If Under		8 Date of B		Monte			r Foreign
	Funeral Director		213-36-3429 Usual Residence of Decedent	1 M 2 1 F	67	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, L June 3	30, Year	37	Latv	lace (State of try) 1a	- Colongia
	Maryland a-f show	ctor	10a. State 10b. County	gomery		ty,Town or L ilver		g						1	0d. Inside Cit 1 ☐ Yes	•
	or 28	Olre	10e. Street and Number				10f. Zip					10g. C	itizen of W	hat Cour	try?	
	ath w	ral	10005 Branch Vie					2090					ited S			
980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther than "natural", or Items 21a be Indiffied at ant, the Medical Examinat must be Indiffied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Da	es? P∑No	l.S. 13.	Was Deced If Yes, spec 1 ☐ Yes		Ispanic Ori in, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	10-		, White,		
ŏ	2 ho	ted	15. Decedent			16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of worki	ina		Kind of Bus			
21218	d within 7 jiene. ir than "n	Completed by	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	Own	se retired	during mos	O WOIN	, ig				Equipm nsulti	
Maryland 21215-0036	ild be file fental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Alberts Jekste	Last)							kste	le, Maide	n Sumame	a)		
ary	shou and M s mar	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mail	ing Address	(Street	and Numbe	er or Rura	al Route Num	ber, City	or Town, S	State, Zip	Code)	
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or 28a-f show may injury or other traumatic event, the Medical Examinat must be notified at ance.		Peter Freivalds, 20a. Method of Disposition 1 □ Burial 2 ▼Cremation		20b. I	10005 Place of Disponentery, cre Mont emator					t, Sil	20c.	Location - (City or To	wn, State	
tim	tment tant: tant:		`4 □Donation 5 □ Other (S)	pecify)	Cr	emator	ium,	Ínc.	1						ryland	
Bal	Depar Impor any ir		21. Signature Fundral Service	0.	1356	Be Be	etheso etheso	ia-Ci la, l	nevy Maryl	chas and	rt _{Inc} . 20814-	3557	Wisc	rune	n Aven	me/ lue
,092	Physician /Medical Examiner	cal Examiner	23a. Part State The disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequential list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a	MATASTI MATAST	(Lip) 51(W) quence of): 1971 (quence of):	m er	e or dyni	y, 30011 d3	Caldida	, isspiratory	unos,			Approximate Interval Betv Onset and E	ween
.O. Box 68	death certific e attending pl d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 Feta int at time of c	al death 3	⊒Ectopic pi ⊒ Other (sp		,				23d. Date Mon			/ear
Q	quires that (n signed by ald be deta	by	Part II. Other significant condition	ons contributing to de	ath but not res	sulting in the	underlying o	ause giv	en in Part I						ne cause of di ably 4 🛣 U	
Vital Records,	n: The law requires that the icate has been signed by the page 2 should be detachen	Completed									per	is an lopsy formed? 2 🔀 N	pi	rior to co eath?	psy findings a mpletion of ca 2 \(\text{No} \)	available ause of
/ita	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?					- 0.1			n (Check only					
of/	Physic this c	ဥ	1 X Yes 2 No			ER/Outpatie		DA Com	er: 4 □ Nu		me 5□Re				y)	
Division (ding h. After fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could	gation		28b. Time of Injury	М		yat k? Yes 2□	No	28d. Describ					
Divi	tal or Attences after death	Certifle	3 ☐ Suicide 6 ☐ Could 6 ☐ Could 6 ☐ Could 6 ☐ determ	ined 286. Place	of Injury - At h g, etc. (Speci	nome, farm, s ify)	treet, factor	y, office			28f. Location City or T	(Street a own, Sta		or Rura	il Route Numi	ber,
	To the Hospital or within 24 hours after To tha Funeral Diracompletely filled in b	edical (g Physician: To the Examiner: On the ba and mann	sis of examina)
	To th within To th	Me	29b. Signature and title of certifie	r			290		e number			29d. D	ate signed	(Month.	Day, Year)	
)	1	2	full tatos	Amil				480	183			May	7 4, 2	2005		
	4		30. Name and address of person Irving Westnei	•				#202	Rock	vill	e, Mar	ylar	nd 208	350		
	Sta Regist		31. Date filed (Month, Day, Year)		gistra's Sign	ature #	, San	D								

TONY D.GAINS 05-02950 RKD

)			State of Maryland / Depa 1- State Unpend Item 23a&27 per me G842-6	irtment of Health and M tilleal5of Beath	, ,	ene 1. No.2 0 0 5	15373
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medi		TONY D. GAINS		APRIL	28, 2005	11:04P. M
	Examir		4a. Facility Name (If not institution, give street and number) 1921 W.LANVALE STREET	4b. City, Town, or Location of Death BALTIMORE		4c. County of De	ath
∞			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A	irthplace (State or Foreign
5	Funeral Director		216-92-6580 1XM 2□F 26 Yrs.	Months Days Hours Min.	(Month, Day,) MARCH 9	'ear) (ARYLAND
S	P .		Usual Residence of Decedent				
	show	č	10a. State 10b. County 10c. City, Town or Loc				10d. Inside City Limits to Type 2 □ No
	the M 28a-f	Director	MARYLAND N/A Bi	ALTIMORE 10f. Zip Code	100	. Citizen of What C	
	3a or		1730 W. LEXINGTON STREET	21223			
	ier death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto I	city Yes or No-	U.S.A 14. Race - Arr Black, Wh	erican Indian,
9	or Ite		1XXvever Married 2 Married 1 Yes 24Xvo	Yes 222No Specify:	nican, etc.)	Specify:BL	
5-0036	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "natural", or Items 23a or 28a-1 show event, the Medical Exerting regal for notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent	ent's Usual Occupation	16	b. Kind of Busines	
	in 72 n *na Neulc	Completed	(Specify only highest grade completed) (Give life, D	kind of work done during most of working NOT use retired)	ng	D. IVAIG OF BUSINES	windustry
212	d withir giene. er than	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade ROOFI	ΞR		HOME IMPI	ROVEMENT
Maryland 2121	2 should be filed with and Mental Hygiene. Is marked other than aumatic event, the	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u> </u>	should be ind Mental marked c	은	ANTHONY MURRAY		IND GAIN		
Mai	d 2 st th and 7 Is n traun			g Address (Street and Number or Rura		Standard Colonia Co	conservacio
	s 1 and 2 should of Health and Meritem 27 Is marke other traumatic	100	20a Method of Disposition 20b Place of Dispos	W. Lexington St., ition (Name of atory or other place)		c. Location - City o	
ê	Pages nent of I int: If it		1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Woodlawn		-05 W	oodlawn,	Maruland
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signatu — uneral Service Licensee 22.	Name and Address of Facility			
<u> </u>	89 = 89	12 1	12016	LLIAM C BROWN COM	MONITY F	UNERAL HO	ME P.A.
			28a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or	r respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive cardio	vascular disease			
	Examiner		Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	sician and burial-transit	Examiner	that initiated events c				
90,	ate be executed hysician and the burial-transif		resulting in death) Last Due to (or as a consequence of):				
8760,	ate hy the	dicai	d				
Box 6	leath certifica attending ph I for use as tl	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	alivery
	death e atter d for u	Physician/Me	in the past 12 months? 1 Ves 2 Ne 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
0	that the de led by the a detached i	hys	9 Unknown				
Division of Vital Records, P.O.	es Ded	ρ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.			robably 4 Munknown
oro:	w requir been sl should	Completed					
Rec	ne law has b	mpi			24a. Was an autopsy performe	d? death?	utopsy findings available completion of cause of
<u></u>	ician: The L certificate ha ector, page	e Co	25. Was case referred to medical	26. Place of Death	1/20 Yes 2		s 2 No
Š	ysician: is certific director,	0 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			e 6 XOther (Spe	ecify)SCENE
Ö	ng Ph fter th neral	n: T	27. Manner of Death 1 ■Natural 5 □ Pending (Month, Day Year) 28b. Time of Injury		8d. Describe how		
siol	ttending Ph death. ctor: After th y the funeral	catio	2 Accident investigation	M 1 Yes 2 No			
Ν	after de la Direct	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 2	City or Town, S	et and Number or H State)	ural Route Number,
_	spital	aj C	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the caus	se(s) and manner a	s stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or inventors) and manner stated.	estigation, in my opinion, death occurre	d at the time, date	and place, and du	e to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	M	29b. Signature and title of certifier	29c. License number		Date signed (Mon	
			/ leader M. Je Jung	O.C.M.E.	API	RIL 29,20	05
			30. Name and address of person who completed lause of death (Item 23a) (Type, F	rint) 111 PENN STREET,BA	ALTIMORE	ΜΔΡΥΙ ΔΝΙΏ	21.201
	Sta	te			TILLIONE,	LEWITENIN	Z1ZU1
	Registr	100	31. Date filed (Month, Day, Year) MAY 0 6 2005 32. Restrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 0544 AM /Medical E. APRIL 18 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba H CSPITA m_0 Baltino! 16 7. Age (In yrs. last bithday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** 8. 9. Birthplace (State or Foreign Country) 1 M 2 F Days Min. Hours 3-80-0580 Director Vorth (arolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-f show other treumstic event, the Medical Examinat must be notified at Director 1 Yes 2 No More 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death Funerai TVZNU 12 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 2 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "I any injury or other treumatic access Secondary (0-12) College (1-4or 5+) É 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 10 mas 20 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmora Ba " MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address Home, P. A. 235" 435 Ba North Ave. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician OMPLETE HEART BLOCK SECONDERY TO ELECTROLITE ABNORMALITY 2 DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of, The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 ☐ Yes 2 ☐ Alo 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 □ No 24a. Was an autopsy performe has certificate 1 Yes 25 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 25 No 1 patient this 2 ER/Outpatient 3 DOA uneral 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: hours after death. unerel Director: After 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 No in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Me of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD AT2438946-E37 2005 APRIL, 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 EAST UNIVERSITY PARKWAY, BALTIMORE, MARYLAND 21218 AGARWAL MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 0 6 2005

			For 1 = State Registrar	State of	Marylan		artmen rtificate			and Me		giene Reg. No. 20	05	1537
	Dhusisi		1. Decedent's Name (First, Middle, L.	ast)						2	2. Date of Dea Month		ear	3. Time of Death
	Physici /Medic		Betty Jane Glo								May 4,	2005		9:30A M
1	Examin	er	4a. Facility Name (If not institution, gi	ve street and num	ber)		4b. City,	Town, or	Location o	f Death		4c. County of	Death	
			Montgomery Hospi 5. Social Security Number 6.					kvil 1 Year	le	24 Hrs C	Data of Die	Monte		
	Funeral Director			1 M 2 X F	7. Age (In yrs. 84	Yrs.	Months	Days	Hours	Min.	B. Date of Birth (Month, Day June 15	, Year) 5, 1920 0	Coun	ace (State or Foreign try)
			Usual Residence of Decedent		04						oune 1.	, 1920 0	пто	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	Od. Inside City Limits
	e Mag	cto	Maryland Montgom	nery	Ro	ckvill	e							1 XYes 2 □ No
	ith th	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of Wh	at Coun	try?
	ath w 23a		305 Lawrence Dri					850				United S		
36	72 hours after death with the Maryland natural', or items 23a or 28s-f show deal Examiner must be nutified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 [X]No e		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec i, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Black, Specify:	America White, 6	etc.
21215-0036	n 72 hours "natural",	Completed by	15. Decedent's E	Education		16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of Busin		
212	within 72 ene. than "n	pie	(Specify only highest gitted Elementary/Secondary (0-12)	rade completed) College (1-	4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired	luring most)	t of working	7			
21	2 should be filed withir and Mental Hygiene. is markad other than aumatic event, the M	Com	Listing in the state of the sta	2		Exec	utive	Ass	istan	t		Federa1	Gov	vernment
P	be filed ttal Hygie od other event,	Be (17. Father's Name (First, Middle, Las	it)					18. Mothe	r's Name (First, Middle,	Maiden Sumame)		
Val	should bind Ment	Tol	Charles E. Lawr	ence		-1			Myr	tle M	Marlin			
Maryland	2 sho		19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Numbe	r or Rural	Route Numbe	r, City or Town, St	ate, Zip	Code)
	s 1 and 2 should be filed within 72 ho f Health and Mental Hyglene, item 27 is marked other then "natur other traumatic event, the Medical		John J. Glock, J	r./Husba		305 Place of Dispo			Drive	, Roc		, Maryla		
Ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from S		ntgome:	natory or o	ther plac	111	ay 6,		20c. Location - Ci	tyorio	wn, State
Ë	t. Pa tmen tant: njury		`4 □Donation 5 □ Other (Spec		Cre	emator	i um.	Inc.		005		Bethesda	, <u>Ma</u>	ryland
Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	Servi	. MO	0803 R	ockvi ockvi	lle, lle,	Inc. Mary	300 1and	West M 20850	lontgomer -2805	y Av	neral Home/ venue
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that ca y one cause on ea	used the deat ich line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_a. Adu	lt Fai	lure t	o Thr	ive						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
	LAGIIIII	_	Sequentially list conditions,	b	or as a conseq	(100 00 of):							-	
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 t0 (t	or as a conseq	dence or).								
	ate be executed hysician and the burial-transit	xan	that initiated events resulting in death) Last	C. Due to (c	or as a conseq	uence of):				-				
8760,	be e sician buria	dical E												
687	ate the	edic		a										
.O. Box (The law requires that the death certifics the has been signed by the attending proage 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		nth 2∏Feta ant at time of d	I death 3	Ectopic pr Other (sp					23d. Date of Month		ry Day Year
<u>α</u>	that the dended by the a		Part II. Dther significant conditions	contributing to de	ath but not res	ulting in the u	nderlyina c	ause give	en in Part I.		23e. Did to	bacco use contrib	ute to th	e cause of death?
ords,	w requires to been signed should be	ted by	Septicemia								1 🗆 Y	es 2 🗓 No 3	☐ Proba	ably 4 □Unknown
of Vital Records,	The law rite has be	Completed by	Peripheral Vasc	ular Dis	ease		· · · · · · · · · · · · · · · · · · ·			_	24a. Was autop perfor	sy prio med? dea	re autop or to con oth? Yes	osy findings available npletion of cause of 2 No
ita	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?						26. Place	of Death (Check only o			
) \(\)	Physician: this certific ral director,	2	1 ☐ Yes 2 X No	Hospital: 1 ☐ Ir	patient 2	ER/Outpatier			4 🗆 140			lence 6 X Other		Hospice
	ttending Plasth. death. ctor: After ti y the funera		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigati		f Injury n, <i>Day Year)</i>	28b. Time o Injury	f 2 M	8c. Injury Work 1 🔲 ՝	rat ⟨? Yes 2 □ I		d. Describe h	ow injury occurred		
Division	of or Atterded after Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place	of Injury - At hog, etc. (Specif	ome, farm, sti	eet, factory	, office		28	If. Location (S City or Tow	itreet and Number n, State)	or Rurai	l Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 11 Certifying F (Check only one) 2 Medical Exa	Physician: To the aminer: On the ba and mann	sis of examina	owledge, deat ition and/or in	n occurred vestigation,	at the tim in my op	ne, date and pinion, deat	d place, an	d due to the of	cause(s) and mann date and place, and	er as sta d due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title absorbitor	11/	\supset		290	. License	number			29d. Date signed (Month, L	Day, Year)
			(TAI)	1/1	~	- 15		100	11	215	2	5/6	- / ,	
	611		30. Name and address of person who	o completed cause	of death (Iten	n 23a) (Type,	Print)		1)	110	1:	7
1	d		Charles M. Ha	rrison,	M.D.	6001 N	funcas	ster	Mil1	Road	. Rock	ville, MI) 2	0855
	Sta	ite	31. Date filed (Month, Day, Year)	0 C 2000	egistra Signa	ture								
	Regist	rar	MAT	0 6 2005	Beers	بلي ر	Sec	W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a, b per phys 9843 5-9-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Month **Physician** 3, May Barbara Gennity 9:05pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6766 Ridge Road Marriottsville Carrol1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Day, Year Min. (Month), Day, Year March 10, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Year) 1□M 20 F Director 023-14-1694 1920 Mass. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be nutified at 1 ☐ Yes 2 ☑ No Director MD Carrol1 Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 6766 Ridge Road Itams 23a 21104 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: à Specify: White 3√ Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 Is markad other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Richard Grav Marjorie Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ann Lofton (Daughter) 6766 Ridge Road Marriottsville, MD 21104 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State pernit. Pages 1
Department of H
Important: If iter
any injury or oth * 4 ☐ Donation 5 ☐ Other (Specify) St. John the Baptist Cem. 5/6/2005 New Freedom, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 Buana Han 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alzheimers Immediate Cause (Final dementia Physician disease or condition resulting in death) 2 years /Medical Due to (or as a consequence of): Examiner Dysphagia 3 months Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sonsequence of): Examine The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760. Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown à signad b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð ostevarthriti of back 2 No 1 Tes 3 Probably 4 Unknown Completed Chromz Back 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Deblin certificate 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director 25. Was case referred to med II Be 26. Place of Death Check onl one examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔭 o P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the Funeral Directory filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D 56531 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10780 Hickory Ridge Rd, Columbia MD 21044

DHMH 17 Rev 1/2001

Registrar

Hamy LI, 31. Date filed (Month, Day, Year)

MAY 0 6 2005

32. Registrar's Signature

*	Pr // Ex
Records, P.O. Box 68760,	The law requires that the death certificate be executed
ta	8n:

The plant of plant (and plant) The plant (and plan				Pleas	se Type or Prin State of Ma	aryland / Dep	artment of H	lealth and l	-	-	gible.	
Physician Medical Examiner Proposition		_		Registrar		CE	ertificate of	Death		15	(1)	17. 22. 25. 298. 199
March 1997		Physici	an	Decedent's Name (First, Middle	, Last)				Month ,	Day	_	3. Time of Death
S. F. CAL Marghal of Body France Search Fran							4. C: T-	. I				1820 PM
Social Sourier Number Color Colo		Examir	ner					4			1	
The control of the											<u> </u>	Jaca (State or Foreign
The Sales The County The				428-38-7638		Vec			(Month, Day	/, Year)	Cour	itry)
WILLIE HUDSON WILLIE	and	M II				10c. City, Town or L	Location				1	0d. Inside City Limits
WILLIE HUDSON MELLIE HUDSON MELLIE HUDSON MELLIE HUDSON	Mary	등급	ţ	MADVIAND N/	` 7 \	ВАТ	ТМОР					1 XX Yes 2 □ No
WILLIE HUDSON MELLIE	the	288 noti	rec		A	DALI				10g. Citizen o	f What Cour	ntry?
WILLIE HUDSON WILLIE	with	38.0		3608 M BEIVED	FDF AVENUE		2	1215		TT G	3 A	
WILLIE HUDSON WILLIE	death	ms 2	Jer 8		12. Was Decedent	Ever in U.S. 13			pecify Yes or No-		ace - Americ	
WILLIE HUDSON WILLIE	after	or to	Ē	1 ☐ Never Married 2 Marri	ied 1.XiYes 2. □I	No			to Hican, etc.)			
WILLIE HUDSON WILLIE	ours a	<u>18</u> T		3 Widowed 4 Divorced	Year or Dates:	44/45	1 L Yes 2€ No	Ѕреспу:		Spec	ify: BLA	CK
WILLIE HUDSON WILLIE	72 hc	natur lical	ted	15. Decedent	's Education	16a. Dec	edent's Usual Occup	ation during most of wor	rkina	16b. Kind of	Business/In	dustry
WILLIE HUDSON WILLIE	thic	. Ban *	du			5+) life.	DO NOT use retired	d)	9			
WILLIE HUDSON WILLIE	M pe	/gien ler th	S			CONS	TRUCTION					STRUCTION
Faith Hudson/Wife 200. Read of Disposation 200. Place of Disposation 200. Plac	96	d off		17. Father's Name (First, Middle, I	Last)			18. Mother's Nar	me (First, Middle,	Maiden Suma	ame)	
Faith Hudson/Wife 200. Read of Disposation 200. Place of Disposation 200. Plac	outd	Men Barke	ပို									
Typerial 2 Committee Commi	N	ls m		19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mai	iling Address (Street	and Number or Ru	ural Route Numbe	r, City or Tow	n, State, Zip	Code)
Deposition of Committees and Committ	C C	fealth rm 27 her t			fe			dere Ave				
236 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval telepone consistent and the interval telepone	ges 1	if ite			3 Removal from State	cometen/ cri	ematory or other place	ce)	Date	200. Location	1 - City or 10	wii, State
236 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval telepone consistent and the interval telepone	Pa	tant: jury							06-05	OWINGS	MILLS	, MARYLAN
236 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval telepone consistent and the interval telepone	ermit	Depar mpor my in		21. Signature uneral Service	D ensee				MMUNITY 1	FUNERAI	_ номе	P.A.
Immediate Cause (Final disease or condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in death) Science of the condition resulting in the condition		02 6 0		10018	Circo Aire Aire Aire Aire - Aire							Angervimate
Medical Examiner Sequentially list conditions Sequential					only one cause on each li	ine.				iest,		Interval Between Onset and Death
Second S	executed III	aminer rial-transit		resulting in death) Sequentially list conditions, Lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):						
Second S	ificat	g ph) as th	edi									
Second S	he death cert	/ the attendin ched for use	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3		y		Y		,
Second S	that	deta		Part II. Other significant condition	ns contributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to th	ne cause of death?
25. Was case reterred to medical examiner? 1	uires	n sign Id be	d b	Cardionyce	athy				1 □ Y	es 2□No	3 ☐ Prob	ably 4 Unknown
performed? 1 Yes 2 No No No No No No No	v req	peer	lete	101					24a. Was a	an 24h	. Were auto	nsv findings available
25. Was case referred to medical examiner? Second Pace Place of Death Check only one	he ia	e has	E G						autop: perfor	sy med?	prior to con death?	inpletion of cause of
28f. Location (Street and Number or Rural Route Number of Rural Ro		ficate or, pa	O	25 Was some referred to modical				OR Plans of Day			1 ∐ Yes	2 No
28f. Location (Street and Number or Rural Route Number of Rural Ro	99	recto	00	examiner?	Hospital:	ent 2 TER/Outrate	ent 301004 Oth	000			ther /Const	v)
28. Place of Injury - At home, farm, street, factory, office 28. Place of Injury - At home, farm, street, factory, office 28. Location (Street and Number or Rural Route Number of Rural Route Numbe		ar this	 		28a. Date of Inju	ury 28b. Time	of 28c. injur	y at				7)
29a. Certifier (Check only one) 29b. Signature and witte of certifier 29b. Signature and address of person who complete cause of death (Item 23a) (Type, Print)	ding	th: : Afte	i i		y	ay Year) Injury						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	al or Atter	s after dea	Sertifica	3 ☐ Suicide 6 ☐ Could r	ined 288. Place of In	jury - At home, farm, s tc. (Specify)	street, factory, office				nber or Rura	l Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ne Hospit	n 24 hour: he Funera		(Check only 2 Medical	Examiner: On the basis of	of examination and/or i	ath occurred at the tir investigation, in my o	me, date and place opinion, death occu	a, and due to the curred at the time, o	ause(s) and nate and place	nanner as st	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To th	withi To tl comp		29b. Signature and title of certifier			_					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				1 >		7	Dos-	000		April	291	2005
		141		30. Name and address of person	who completed cause of c		e, Print)	ilir "Te	3-22	11/11	10 000	
TAN WEIR NO SINU HISAITAI		1.		TAN.	WEIR. DO		SINGI H	rspital				
State 31. Date filed (Month, Day, Year) 6 2005 Registrar				31. Date filed (Month, Day, Year)	6 2005 32. Figistr	rar's Signatur	house					

		1 - For State Registrar	State of Maryland / Dep		Mental Hygiei	2005 150-
Physic /Med Exam	lical	1. Decedent's Name (First, Middle, Las Kelvin 4a. Facility Name (If not institution, give Good Samarita	Har e street and number)	UKINS 4b. City, Town, or Location of Death Baltimore	05 0	Day Year 3. Time of Death 2 2005 10:59 4 M County of Death Caltimore
Funera Directo		5. Social Security Number 6. S		Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreig Country)
within 72 hours after death with the Maryland ene. then "netural; or items 23e or 28e-f show its Maryland is Maryled Examined."	Funeral Director	MD 10e. Street and Number 3108 WOOD R	ING AVE.	101. Zip Code 21234	, 10g.	1 V Yes 2 □ No Citizen of What Country? US- A.
72 hours after death w "netural", or Items 23e	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 DEYes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S _I If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: SUACK
D . D .	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	de completed) (Give	adent's Usual Occupation A don't do work do find during most of work BO NOT use retired; CHEF	king 16b	FOOD
MICILY ICALING A 1 A 1 A 2 Should be filed within th and Mental Hygiene. 77 is marked other then treumetic event, ITE M.	To Be	17. Father's Name (First, Middle, Last, JOSEPH 19a. Informant's Name/Relationship (HAVKINS Type, Print) 19b. Mail		ONNE T	YEK
tges 1 and 2 at of Health a if item 27 is or other tree		TAWNYA K. HAT 20a. Metbod of Disposition 1 Burial 2 □ Cremation 3 □	Hemoval from State .	osition (Name of omatory or other place)	Date 20c	WRE, MD 21234. Location - City or Town, State
t. P.c. rtmer rtent	KIIKS.	*4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	MOKELANI	D CEMETERY 3 . 9 12. Name and Address of Facility VA BATIMORE, MARY	WHIN C. GA	MT i MORE, MARYLAND REENE FEWERAL HOME . YOU YORK ROAD
Fnysiciai /Medica Examine		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	plications that caused the death. Do not erone cause on each line. a	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	Ilcal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):			
The law requires that the death certificate are the bear signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed t	b	Part II. Other significant conditions of	contributing to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes	
	Be Completed	25. Was case referred to medical examiner?		26. Place of Dea	24a. Was an autopsy performed 1 □ Yes 2 □ th (Check only one)	
Physicien: r this certifica	To	1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing H	ome 5 Residence	e 6 □Other (Specify)
or Attending ifter death. Director: After in by the fune	Medical Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	8 Ose Blees of Injury At home form of	Work? M 1 □ Yes 2 □ No	28f. Location (Street City or Town, St	t and Number or Rural Route Number,
To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	(Check only 2 Medical Exar	lysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
To to to to to to to to to to to to to to	X	29b. Signature and title of certifier	MD.		87	05 /02 / 20 05
")		30. Name and address of person who	completed cause of death (Item 23a) (Type 10 MAT MD, To 01 32. Registrar's Signature	, LOCH RAVEN	BWD.	BALFMORE, MD-2/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 4, 2005 **Physician** 10:35 AM Chuan-Pu Hsiung /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F 1918 Director May 10, China 231-17-6474 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State iral', or Items 23a or 28a-f show LEverali vermust be notified at 1X Yes 2 No Maryland Rockville Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19 Martins Square Lane 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 Yes, Give 1 Nevar Married 2 Married "natural', or 1 ☐ Yas 2X No Specify: If Yes, Give Year or Dates: Specify: Asian Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 4 Finance Officer <u>Army of China</u> permit. Pages 1 and 2 should be filed. Department of Health and Mental Hverimportant: If tem 27 is metrany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jia Yuan Hsiung Unknown Luo 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Hsiung/Son 7338 Lochhaven Court, Allentown, Pennsylvania 18106 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition May 7, 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 □Donation 5 □Other (Specify) 2005 Bethesda, Maryland 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc. Pumphrey Funeral Home/ . 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee M01346 Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final a Pneumonia **Physician** 1 Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure 10 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Cerebral Vascular Accident use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year jo Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2**X** No 1 Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 \(\tau \) Nursing Home 5 \(\tau \) Residence 6 \(\tau \) Other (Specify) 2 1 ☐ Yes 2 X No 1 🗶 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death after death. Certification; 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 🔀 Cartifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. edical

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by 24 hours a within 2 To the

Baltimore, Maryland 21215-0036

State Registrar (Check only one)

29b. Signature and title of certifier

Mo-Ping Chow, M.D., 31. Date filed (Month, Day, Year)

and manner stated.

32. Registar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 0 6 2005 Meeur

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D0052457

8910 Medical Center Drive, Gaithersburg, MD 20850

29d. Date signed (Month. Day, Year)

May 4, 2005

			1 - For State Registrar		State	of Maryla	and / Depa <i>Ce</i>	artmen <i>rtificat</i>			and Me		giene Reg. No	005	15.	381
	Physicia	an .	1. Decedent's Name (First, M	liddle, Last,		a calesi						2. Date of Dea Month	Day	Year	3. Time o	of Death Opm M
	/Medic Examin	al	Frances 4a. Facility Name (If not instit	ution, give	Hilit street and no			4b. City,	Town, or	Location o		April		OU5 County of Dea		PIII ™
	Examin	er	Cherry Lane Nur			·			ırel				1	ince G	eorges	
	Funeral Director		5. Social Security Number 161–22–7277		х]м 2 75 .	7. Age (In y 93	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	B. Date of Birt (Month, Da June 14	, Year) , 1911	_ C	thplace (State ountry) e, PA	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. Co.			10c.	City, Town or Lo	ocation							10d. Inside C	City Limits
	a-f sh	ctor	MD Pri	nce Ce	orges		Lat	rel							1 ☐ Yes	2 111√0
	with the	Director	10e. Street and Number 9001 Cherr	y Lane				10f. Zip	Code 20726				10g. Citiz US.	en of What Co A	ountry?	
	ms 234	Funeral	11. Marital Status	у папе	12. Was Dec	cedent Ever in		Was Dece	dent of His	spanic Orig	gin? (Spec	ify Yes or No-		4. Race - Ame		
0000	urs after o el', or iter	þ	1 ☐ Never Married 2 ☐ 3 🔀 Widowed 4 ☐ Divo		Armed F 1 ☐ Yes If Yes, G Year or	2 No		If Yes, spe 1 ☐ Yes		Specify:	i, Puerto Ri	ican, etc.)		Black, White Specify: W	nite	
5	72 hou	eted	15. Dece (Specify only hi	dent's Edu)	16a. Dece	kind of wo	rk done d	uring most	t of working	,	16b. Kin	d of Business	/Industry	· · · · · · · · · · · · · · · · · · ·
7	within ene. than "	Completed	Elementary/Secondary (0-			(1-4or 5+)		oo ndt u omemal					Own	n Home		
and z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentla Hygiene. Importent: If learn 27 is marked other than "naturel", or Items 23a or 28a-f show importent: If learn 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, Ite Madical Examinar matable and lifed at once.	Be	17. Father's Name (First, Mid Konstanty		macki				T		or's Name (First, Middle, Balc				
a Z	shoul and Me s mark	To	19a. Informant's Name/Relat					-				Route Numbe	-		Zip Code)	
₹ 15	and 2 lealth a m 27 i		Stan Hilins	ki/S	Son	201	. Place of Dispo			mi D	rive Da	Laurel		20707 ation - City or	Tour State	
Dallimore	Pages 1 ment of H ent: if ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat 1 ☐ Donation 5 ☐ Other			State	cemetery, cre	matory or o	ther place	a)	5/21			e,PA	Town, State	
סמור	permit. Departi import any inj		21. Signature of Funeral Ser	vice Licens	6 0		2	2. Name a Charle 1501	s L.	Steven	is Fund	eral Hom	e Inc. MD 212	230		
	Physician		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition	e, or compl List only o	ne cause on	caused the deach line.		ter the mod	te of dying	, such as	cardiac or	respiratory ar	rest,		Approxima Interval Be Onset and 3 day	tween Death
	/Medical Examiner		resulting in death)		Due to	o (or as a cons	sequence of):									
	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	b. Due to	o (or as a cons	sequence of):									
Ď,	e execution and curial-tran	I Examiner	that initiated events resulting in death) Last	1	Due to	o (or as a cons	sequence of):									
00/00	ficate by physic s the b	edical		•	d											
C. DOX	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t	1 Live	utcome of pre birth 2 F gnant at time o nown	etal death 3[⊒Ectopic p ⊒ Other (s _j					2:	3d. Date of de Month	-	Year
J. L.	The law requires that the site has been signed by the page 2 should be detache	by	Part II. Dther significent cor		ntributing to	death but not	resulting in the u	inderlying (ause give	n in Part I.		23e. Did to			the cause of	
SDLOS	w requ	Completed	Diabetes									24a. Was		24b. Were a	utopsy findings	available
E C	sicion: The law certificate has b lirector, page 2 s	omb	210,000										rmed? 2 No	death?	completion of a	cause of
VII.al	icien: sertifica ector,	Be	25. Was case referred to me examiner?		Hoenital:				Otho	_ /		Check only o				
5	Phy this	on: To	1 ☐ Yes 2 ☑ No 27. Manper of Death 1 ☑ Natural 5 ☐ Pe			Inpatient 2 of Injury onth, Day Year	ER/Outpatie	i le	28c. Injury Work	at ?	28	e 5 Resid			cify)	
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certificat	3 ☐ Suicide 6 ☐ Co	estigation ould not be stermined	289. Plac	ce of Injury - A	t home, farm, st	reet, factor		′es 2 🔲		Bl. Location (S City or Tox		Number or R	ural Route Nur	mber,
ב	pital cours af erel D filled in		29a. Certifier 1 Cert	rifying Phy	sicien: To th	ne hest of my	knowledge, deal	th occurred	at the tim	e date an	id place, as	nd due to the	cause(s)	and manner a	hates a	
	ne Hos n 24 hi ne Fun sletely	edical	(Check only 2 Med one)	icel Exami	iner: On the and ma	basis ol exam nner stated.	ination and/or in	vestigation	i, in my op	inion, dea	th occurred	d at the time,	date and	place, and due	to the cause(s)
	To the To the Comp	M	29b. Signature and title of ce	rtifier (Cecus	lu M	A.		DO036					signed (Moni 1 28, 20	h, Day, Year) 005	
	V		30. Name and address of pe Andrew Kundi	rson who c	ompleted car	use of death (MD 20	726			•			
150	Sta Registr		31. Date liled (Month, Day,)		05 3	Registrar's Si	gnature &	ante)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:35 PM **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner mmiNGBIRI 36733 8. Date of Birth (Month, Day, Year) 7/20/40 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days 1□M 21 F 5 Yrs. 577-64-0120 Director Usual Residence of Decedent 10c. City, Town or Location the Maryland 10d. Inside City Limits 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1 Yes 2 Mo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 05 mming BIRD 36733 Items 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No filed within 72 hours after 1 Never Married 2 Married 0 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: () þ 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) REPRESENTATIVE 10 other permit. Pages 1 and 2 should be file.
Department of Health and Meniar important: if Item 27 is many Injury or other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARILDI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 36733 HUMMINGBIRD MECHANICSVILLE, MD DEBORAH TAYLOR 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ANATOMY GIFTS REG. 4 Donation 5 Other (Specify)
Signature of Findal Price Licensee 22. Name and Address of Facility 21. Signatu Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part1. Enter the disease, or emplications that caused the shock, or heart failure. List only one cause and failure. Approximate Interval Between Onset and Death Do not enter the moda of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** End-Stage Renal resulting in death) /Medical Due to (or as a consequence of): Examiner Medullary Spange Due to (or as a consuence of): Medullary fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should he Advantage. resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1XYes 2□No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? DISEASE OBSTRUCTIVE NG 24a. Was an HRONIC autopsy performe 2 No 1 Tyes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of centries 29c. License number 29d. Date signed (Month, Day, Year) 02/05 D0013071 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clinton

DHMH 17 Rev 1/2001

State Registrar Gurbux

31. Date filed (Month, Day, Year)

Nachnani

8926 Woodyard

32. Registrar's Signature

601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** SENSEN JR 1530 P.M OSCAR CHARLES 2005 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NOR THWEST HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. BALT, MORE 8. Date of Birth (Month, Pay, Yea 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 F Months 70 220-30-6601 Director Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10h County 28e-f show Examiner must be notified at 1 ☐ Yes 2 PNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö .S.A 2106 SOUT "neturel', or Items 23a by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne any injury or other treumatic event. If a Medic. Elementary/Secondary (0-12) Colle (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HELEN HUGHES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) South GLENBURNIEMD. ZIOBI PAN H 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23af Pa 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause of each Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final hour Physician Dulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a construence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last b. Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a cons quence of): the attending physician and hed for use as the burial-tran Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performer 2 🖾 No 2 🔀 No 1 TYes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 No death. investigation after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funerel C 29a. Certifier Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier DO059736

Registrar

DHMH 17 Rev 1/2001

State

DEBORAH

31. Date filed (Month, Day, Year)

NORTHWEST

32. Registar's Signature

Rasus

HUSPITAL

OLP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WATSEN

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Death

12:40 A

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 No

2085

1 Tyes

50 minutes

Year

ty Yes 2 □ No

Birthplace (State or Foreign Country)

Florida

2005

ND

MY

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATO

Sports

ORIGINAL

D36817

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State

Registrar

GREGORY

31. Date filed (Month, Day, Year)

)3104		State of Maryland / Depart State of Maryland / Depart State Unpend Item 23a, 27, 28a-1 per me Grant Registrar		-	_	15385
Physici	an	1. Decedent's Name (First, Middle, Last) Kathleen Frances Jones		2. Date of Deat May 5,		3. Time of Death 0220 A M
/Medio Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Nov. 26	Year) Cour	place (State or Foreign htry) cyland
tryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local MD MD Baltimore Ess			1	0d. Inside City Limits 1 ☐ Yes ※☐ No
h the Ma or 28a-f	irecto	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cour	
eath wil	erai D	629 Delaware Ave. 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	21221 as Decedent of Hispanic Origin? (Sp.		USA 14. Race - Americ	can Indian,
urs after d	by Funeral Director	1 □ Never Married 2 No Married 1 □ Yes 2 No	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐ Yes 2	Rican, etc.)	Specify: White,	
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. When then "natural", or iteme 23a or 28a-f ehow ant, the Madical Example Marinal be notified at	Completed		nt's Usual Occupation ind of work done during most of work O NOT use retired) maker	ing	16b. Kind of Business/In OWN home	
Tey, Widdly graffing Z 12 10 0000	To Be Co	17. Father's Name (First, Middle, Last) Milton Redyk	18. Mother's Name	e (First, Middle, M		
2 should be and Mental is marked or raumatic every	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Run	al Route Number	, City or Town, State, Zip	Code)
of Health		20h Place of Dispos	atory or other place)		MOTE MD 20c. Location - City or To Baltimore	
permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other		4 Donation 5 Other (Specify)			FuneralHom	
Depa Impo		R. Terry Comelly	300 Mace Ave.	Baltimo	re MD 212	21 Approximate
Physician		23a. Part 1. Enter the disease, or completions that caused the deal note shock, or heart failure. List are ne cause on each line. Immediate Cause (Final disease or condition Methadone intoxical				Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):				
ited	Examiner	Sequentially list conditions, any leading to limit data cause. Enter Underlying Cause (Disease or injury				
FOU, e be executed rsician and e burial-transi	cai Exa	that initiated events resulting in death) Last Due to (or as a consequence of):				
Certificate certificate ding phys	/Medic	IF FEMALE: 23c If was outcome of pregnancy			23d. Date of deliv	erv
death death death death	Physician/Medi	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 I	Ectopic pregnancy Other (specify)		Month	Day Year
COTGS, P.O. IN requires that the speen signed by the should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.		bacco use contribute to t es 2∰No 3□Prol	he cause of death? pably 4 Unknown
Hec e law has b	Completed			24a. Was a autops perform	sy prior to co	opsy findings available impletion of cause of
r VICAL Pysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Deal	th (Check only on		6.1
og Physiter this	tion: To	27. Manner of Death 1 Natural 5 Pending Pound Day Year) 28a. Date of Injury 28b. Time of Found Found Day Year)	28c. Injury at Work?		ow injury occurred	unk
DIVISION C el or Attending P s after death. Il Director: After i d in by the funera	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 5 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Scene	et, factory, office	28f. Location (Si City or Town Essex, M	treet and Nugber of Burn n, State 629 De 1a	al Route Number. Ware Ave.
Hospitel (24 hours at Funerel Dietely filled i	Medicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place,	and due to the c	ause(s) and manner as s	stated. to the cause(s)
To the P within 2 To the F complete	Me	29b. Signature and title of certifier	29c. License number OCME		29d. Date signed (Month.	Day, Year)
m		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) 111 Donn Charact		ay 5, 2005	1 04004
(') St	ate	31. Date filed (Month, Day, Year) MAY 0 6 2005	111 Penn Street	Daltimo	ore, Marylar	na 21201
Regis		MAY 0 6 2005				

ORIGINAL

05-03030 Mark Jones

			_ FOI	epartment of Health and N Certificate of Death		ene 1. No. 2 () () 5	10000		
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death		
	Physici		MARK C. JONES		Month May (01. 2005	13:53 M		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
1		•	Johns Hopkins Hospital	Baltimore					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	9. Birth	place (State or Foreign intry)		
п	Director		215-78-2301 XXM 20F 40	rs.	AUGUST 2		MD		
	D ≥ //3		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits		
	anyla shov	×	,			1	1 XYes 2 No		
	he M	ecto	MD BALT 10e. Street and Number	IMORE 10f. Zip Code	100	g. Citizen of What Cou			
	with le or	늅			100		into y .		
	eath	Funeral Director	504 E. 26th STREET 11. Marital Status 12. Was Decedent Ever in U.S.	21218 13. Was Decedent of Hispanic Origin? (Sc	ecify Yes or No-	USA 14. Race - Ameri	ican Indian,		
	ter d	'n.	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Married	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Black, White			
336	urs al	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: BLA	CK		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Medical Examinat must be notified at	Completed		Decedent's Usual Occupation Give kind of work done during most of work	16	3b. Kind of Business/I			
21	hin 7	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	ang .				
21	ad will	Con	10	CONSTRUCTION WORKER		CONSTRUC	CTION		
pu	be file	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Sumame)			
Na Na	Ment Ment arke	70	ALVIN JONES		TAYLOR				
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "' traumatic evant, the Med			Mailing Address (Street and Number or Rui		-	p Code) 21218		
	t. Pages 1 and trinent of Healt trant: if item 2 land				TIMORE, M	Oc. Location - City or T			
Baltimore			1 Burial 2 Cremation 3 Removal from State	crematory or other place)		BALTIMORE,			
ţ			*4 □Donation 5 □ Other (Specify) MT • Z1 21. Signature of Funeral Service Licensee						
Ba	permi Depar Impoi any ir		James 9. Morton	22. Name and Address of Facility JAJ 1701–31 LAURENS ST		ORE, MARYL	S F.H., INC. AND 21217		
г			23a. Part Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition a. Multiple guns)	not wounds			Orisot and Doath		
	/Medical Examiner		resulting in death) Due to (or as a contequence of						
н	=X4	<u>L</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of						
	led sit	nlne	cause. Enter Underlying Cause (Disease or injury						
	be executed sician and burial-transit	xar	that initiated events c						
8760,	cate be execu	dical Examine	C _d						
89	ificate g phys	edic	<u> </u>						
Box	death certifics attending phase as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of deliv	*		
	death e atte	icla	in the past 12 months? 1 Yes 2 No 9 Unknown	5 Other (specify)		Month	Day Year		
P.0	that the death cer ed by the attendin detached for use	hys	9 ☐ Unknown						
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by F	Part II. Dther significant conditions contributing to death but not resulting in	he underlying cause given in Part I.		cco use contribute to			
ord	equir sen si ould	ted			1 ☐ Yes	2. No 3□ Pro	babiy 4 □Unknown		
Records,	has be	Completed			24a. Was an autopsy	prior to co	opsy findings available empletion of cause of		
- H		Con			performe 1 XYes 2		2 No		
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		h (Check only one)				
of	this at dii	10	1 N Yes 2 No 1 I Inpatient 2	ALIGHT 30 DOX 40 Not Sing Fit	ome 5 Resident	ce 6 Other (Speci	fy)		
Division of	ling After	lon	1 Natural 5 Pending (Month, Day Year) In	ury Work?	S. L.		hot		
18	Attending ir death. actor: After by the fune	lica	3 ☐ Suicide 6 ☐ Could not be 20 = Black of laiver, At home for	2 7	28f. Location (Stre	et and Number or Rur			
Θ	after Dira	Certification:	4 Phomicide determined building, etc. (Specify)	•	2900 Block	State) L Greenmou	wit Ave		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, 2. Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place,			stated.		
	o tha ithin i o tha omple	Mec	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)		
	4		Hashar Greenly no	O.C.M.E.		May 02, 20	005		
0-	-		30. Name and address of person who completed cause of eath (Item 23a) (1	ype, Print)		1 1 04 04	24		
9			30. Name and address of person who completed cause of the 23a) (1) Tasha Z Green berg M.D. 11.	Penn Street, Balti	more, Mar	cyland 2120)T		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 6 2005	foods					

Health and Mental Hygiene

GEORGE L. JENKINS	State of Maryland / Department of H
1 - For Stata Registrar	Certificate of

			1 - Stata Registrar			Cen	tificate	e of .	Death)		Reg. N	lo		
	Physic	ian	1. Decedent's Name (First, Middle, Last								2. Date of D	-	Z U Ve	5	3. Time of Death
	/Medi		GEORGE LEONAR		S JR						MAY 4	+, 2	005 Ye	ar	1825 P w
1	Exami	ner	4a. Facility Name (If not institution, give 3424 GUILFORD TE	RRANCE					DRE C			4c. County of Death			
	Funeral Director			714 600	(In yrs. last birtl	rs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di August	rth a <i>y, Yea.</i> 1, 1 9	9. V	Count	ace (State or Foreign ry) 1nia
	within 72 hours after death with the Maryland ane. sne. than "naturel", or Items 23a or 28a-f show the Modical Everiner must be notified at	ctor	Usuel Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City, Town Baltimo		ation							10	d. Inside City Limits
36	ith the	Direc	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What	Count	
	s 23a	rall	3424 Guilford Ter					212					USA		
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, if a Modical Exertirer must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed ★★ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes ②XXN If Yes, Give Year or Dates:	ver in U.S.		as Deced Yes, spec		ispanic Or in, Mexica Specify:		ecify Yes or Ne Rican, etc.)	0-	14. Race - A Black, W Specify:		tc.
5-0036	72 hou	Completed	15. Decedent's Edu	ication	16a. [Decede	nt's Usua	l Occup	ation			16b.	Kind of Busine	ss/Indi	ustry
2121	ithin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	F)				du <i>ring m</i> os ()		ng				
121	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, It a Me		17 Fathada Nama (First Adiddle Lank)	4		Com	puter	^ Di	visio					ecu	rity Admin
anc	ntal Hed of	Be	17. Father's Name (First, Middle, Last) George Leonard Je	anking Sr					_	er's Name Innie	(First, Middle	, Maide	n Sumame)		
Maryland	should I nd Men marke	2	19a. Informant's Name/Relationship (Ty		19h	Mailing	Address	(Street			l Route Numb	or City	or Tour Stat	o Zin (Code)
	1 and 2 s Health ar em 27 ls ither treu		Joseph C Dungan		/EXEC	34	24 Gu	uilf	ord T	erra	ce Balt	timo	re, Ma	ry l a	and 21218
ore	ges 1 t of He If item or oth		20a. Method of Disposition 1 ☐ Burial	Jamoual from State	20b. Place of I cemetery		tion (Nam		e)	D	ate	20c. L	ocation - City	or Tow	m, State
Ë	Pages Iment of I tant: If it		Donation 5 Other (Specify)	-/	GreenM				•	5/6/					aryland
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		2) Fignature of Funeral Service Licens	1 Nous	. h.	22.	Name and	d Addres			hell-Wie				
			23a. Part1. Enter the disease or compl	ications that caused	the death. Do no	nt enter	the mode	of dvin			Road Ba		ore, Mar		Q Z Z Z Approximate
	Prrysician /Medical Examiner	ər	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate	Due to (or as a	CONSEQUENCE OF	'):	c Ca	vd	iova	ecci	Jav	Di	se ces	1	nterval Between Onset and Death
68760,	certificate be executed iding physician and ise as the burial-transit	VMedical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	consequence of										
P.O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□ Unknown	Fetal death		ctopic pre Other (spe						23d. Date of o		/ ay Year
Ś	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	þ	Part II. Other significant conditions cor	ntributing to death but	not resulting in t	he und	lerlying ca	use give	en in Part I			obacco Yes 2	_	to the	cause of death?
Vital Record		Completed									24a. Was autor perfo	an osy med? 2 X No	prior t death	to comp	y findings available pletion of cause of
Vita	i cien : Th certificate rector, pag	Be	25. Was case referred to medical examiner?	la itali				Tai		of Death	(Check only o	ne)			
of	Phys this al dii	To To	1 X Yes 2 No P		t 2 ER/Outp		3 DO/	-	4 LI NU	-				pecify).	AT SCENE
	fter	atlon	1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Ye <i>ar)</i> 28b. Tir Inji	ury	M Z	ic. Injury Work	at ? ′es 2 ∐ l		8d. Describe f	now inju	ry occurred		
Division	tel or Attending s after death. bl Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	n, stree	t, factory,	office		2	8f. Location (5 City or Tox	Street ar vn, State	nd Number or e)	Rural F	Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical (29a. Certifier (Check only one) 1 Cartifying Phys	sician: To the best of ner: On the basis of e and manner state	examination and/	death o	occurred a stigation,	t the tim	e, date and inion, deat	d place, a th occurre	nd due to the d at the time,	cause(s date an) and manner d place, and d	as stat ue to th	ed. ne cause(s)
)	To To Conm	2	29b. Signature and title of certifier Or OF F	tela	inn	Ld	A	License OCME	number			29d. Da MA	te signed (Mo		
1	2		30. Name and address of person who co	LINI	ld	1	.11 P	enn	Stre	et E	Baltimo	re,	Maryla	and	21201
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar	's Signature	200	(h)								

		Pleas 1 - For State Registrar	e Type or Pri State of M	laryland / De		Health and N	Mental Hyg	_	ble.	326
Phys		Decedent's Name (First, Middle, Jerry W		bs			2. Date of Dear Month May 4		Year 3. Time of D	
	dical niner	4a. Facility Name (If not institution, Stella Maris			Time	or Location of Death			altimore	
Funer Directo		218-58-3306	1. Sex 7. A	ge (In yrs. last birthda 52 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day October 6	, 1952	9. Birthplace (State or Country) South Carolin	Foreign a
Aaryland f show	io	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore	10c. City, Town or					10d. Inside City 1 ☐ Yes 2	
3a or 28e-	Funeral Director	10e. Street and Number 28 Dunvale Road		1000	10f. Zip Code 2120)4	1	0g. Citizen of V	Vhat Country?	٨
be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than "natural", or Itema 23a or 28e-f show event, the Medical Expertant must be notified.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1	? X Vo	3. Was Decedent of In If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac	e - American Indian, k, White, etc.	
p 6 5	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+) (Gi	cedent's Usual Occup ve kind of work done . DO NOT use retire ever emplo	during most of work yed	ing		n/a	
	Be	17. Father's Name (First, Middle, La				18. Mother's Nam			e) Reed	
and 2 should be file saith and Mental Hy n 27 is marked oth	OT.	John C. 19a. Informant's Name/Relationship Tammy Coccagna—			iling Address (Street	and Number or Rur	al Route Number	, City or Town,	State, Zip Code)	
	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	cemetery, ci	position (Name of rematory or other pla Service (ce)		20c. Location -	City or Town, State	
permit. Pages 1 a Department of Hec Important: If item any injury or othe	- BOUCE	21. Signature of Lineral Service Lie			22. Name and Addre		ck Towson	Funeral I		
Physician and as the purish-transit as the purish-transit	Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	a. LUNG C Due to (or as						Interval Betwee	
The law requires that the death certificate be the has been signed by the attending physicic bage 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	B Ectopic pregnancy	у		23d. Dat M <i>o</i> r	e of delivery ath Day Yea	ar
w requires that been signed t	by	Part II. Other significant conditions	s contributing to death	but not resulting in the	underlying cause giv	ven in Part I.			ibute to the cause of dea	
	e Completed	25. Was case referred to medical					24a. Was ar autops perform 1 \sum Yes 2	y p ned? d XX No 1	Vere autopsy findings avarior to completion of causeath? ☐ Yes 2☐ No	ailable se of
	To Be	examiner? 1 \(\sum \text{Yes} \) 2\(\overline{\overli	Hospital: 1Inpati	ent 2 ☐ ER/Outpati	ent 3 DOA Oth	26. Place of Death ner: 4 ☐ Nursing Ho	me 5 Reside		er (Specify) HOSPI	CE
ding h. After fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigat		ury 28b. Time lnjury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurre		
tal or Attenres after deatl	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	ad 286. Place of in	jury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office		28f. Location (Str City or Town	reet and Numbe , State)	er or Rural Route Numbe	ir,
To the Hospitat or within 24 hours after To the Funeral Director Completely filled in b	edical	(Check only 2 Medicel Ex	Physicien: To the best aminer: On the basis a and manner s	of examination and/or	investigation, in my o	pinion, death occurr	ed at the time, da	ite and place, a	nd due to the cause(s)	
To the within 2 To the complet	M	29b. Signature and little of certifier	<u>. </u>		29c. Licens	3725	29	od. Date signed	(Month, Day, Year)	
Ì		30. Name and address of person when DR. TARIO MAHM	00D 2300 i	THE ANEX WA		TIMONIUM,	MD 210	93		
Regi	State strar	31. Date filed (Month, Day, Year) MAY 0 6 20	32. Regist	rar's Signature	ME)		,			
DHMH 17 Rev	1/2001	man y y a y	A CONTRACTOR OF THE PARTY OF TH	1	200					

UNIMIN 17 Nev 1/200

George Koppelman

Physician /Medical

Examiner

Funeral Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Exarchment to nothing an

Physician

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

		ledical aminer
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Function Director. After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit

63

State Registrar	Certificate	of Health and Me of Death	Reg. N	63	
Decedent's Name (First, Middle, Last)			2. Date of Death	2000	3. Time of Death
George Koppelman a. Facility Name (If not institution, give street and number,	4b. City, 1	own, or Location of Death	April	29, 2005	06:35A
ood Samaritan H	ospital Bal	timore		NA	
Social Security Number 6. Sex 7. At 14-16-3173 12M 2 F	ge (In yrs. last birthday) If Under 1 84 Yrs. Months	Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	place (State or Foreign htry) ULand
sual Residence of Decedent			Oct. 10,	1920 Mari	yland
a. State 10b. County aryland N/A	10c. City, Town or Location	timore		1	Od. Inside City Limits 1 □YYes 2 □ No
e. Street and Number	101. Zip (10g. C	Citizen of What Coun	
5635 Anthony Avenue		21206			S.A.
Marital Status 12. Was Decedent Armed Forces 1 Never Married 2 Married 1 X Yes 2 □	? If Yes, specif	ent of Hispanic Origin? (Spec fy Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
	(III) TT 1 Yes 2	No Specify:		Specify: Wh	iite
15. Decedent's Education (Specify only highest grade completed)	life. DO NOT use	done during most of working	g 16b.	Kind of Business/Inc	dustry
Elementary/Secondary (0-12) College (1-4or 12th Grade	5+) Mechani		D.	iesel Eng	ines
Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide		
John Koppelman a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Emma Street and Number or Rural	Christ Route Number, City	Tour State Zin	2- del
		iony Ave., Ba			Соав)
a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disposition (Name cemetery, crematory or oth	e of Da	ate 20c. I	Location - City or To	
4 □Donation 5 □ Other (Specify) Signature of Funeral Service Licensee	Parkwood Cemet		005 Ba		
Dein a. Weller	9705 Be	Address of Facility Sch Lair Rd., Ba	imunek tur Ptimore. N	reral Home ID 21236	28
Ba. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	d the death. Do not enter the mode				Approximate Interval Between
nmediate Cause (Final sease or condition sulting in death)	5				Onset and Death
Due to (or as	s a consequence of):				
equentially list conditions, b	a consequence of):				
any, leading to immediate Due to (or as ause. Enter Underlying	•				
ause. Enter Underlying ausa (Lisease or ir jury) at initiated events c.	a consequence of:				
ause. Enter Underlying ausa (Lisease or ir jury) at initiated events c.	a consequence of):				
ause. Enter Underlying Ause. Character in jury at initiated events sulting in death) Last C. Due to (or as					
Luse. Enter Underlying was if its assume in fury at initiated events sulting in death) Last C. Due to (or as d. FEMALE: b. Was decedent pregnant in the past 12 months?	of pregnancy 2 ☐ Fetal death 3 ☐ Ectopic preg			23d. Date of deliver	ry Day Year
Lusée. Enter Underlying varies a ("stass of it fur") at initiated events sulting in death) Last C. Due to (or as d. FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal death 3 Ectopic pregnancy 5 Other (spec	cify)			,
Lase. Enter Underlying at initiated events in the past 12 months? I Great Initiated events is sulfting in death) Last C. Due to (or as d	of pregnancy 2 Fetal death 3 Ectopic pregnancy 5 Other (spectation of the death 5 Other (spectation) 5	cify)		Month I	Day Year eause of death?
Asset Enter Underlying at initiated events at initiated events sulfting in death) Last C. Due to (or as d	of pregnancy 2 Fetal death 3 Ectopic pregnancy 5 Other (spectation of the death 5 Other (spectation) 5	cify)	1 ☐ Yes 2	Month I use contribute to the	Day Year a cause of death?
Enter Underlying at initiated events sulting in death) Last C. Due to (or as d. FEMALE: b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown TII. Other significant conditions contributing to death b	of pregnancy 2 Fetal death 3 Ectopic pregnancy 5 Other (spectation of the death 5 Other (spectation) 5	cify)	1 Yes 2	Month I use contribute to the I No 3 Proba	Day Year e cause of death? ably 4 Minknown sy findings available ipletion of cause of
Enter Underlying was a Company at initiated events sulting in death) Last C. Due to (or as d. Due to (or as d. Due to (or as sulting in death) Last FEMALE: B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown A CUTE RENALE 1 Live birth 4 Pregnant at 9 Unknown A CUTE RENALE 1 C. Due to (or as d. Due to (or as	of pregnancy 2 Fetal death 3 Ectopic pregnancy 5 Other (spectation of the death 5 Other (spectation) 5	cify)	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 2 N	Month I use contribute to the I No 3 Proba	Day Year e cause of death? ably 4 Minknown sy findings available ipletion of cause of
Lise. Enter Underlying at initiated events sulting in death) Last C. Due to (or as d. Due to (or as d. Due to (or as sulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown TII. Other significant conditions contributing to death by the conditions contributing the conditions contributing the conditions contributing the conditions contributing the conditions contributing the conditions co	of pregnancy 2 Fetal death 3 Ectopic pregnancy 2 The fetal death 5 Other (special pout not resulting in the underlying cause) Out The fetal death 5 Other (special pout not resulting in the underlying cause) Out The fetal death 5 Other (special pout not resulting in the underlying cause)	26. Place of Death (1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 2 No. Check only one) 5 Residence	Month I use contribute to the I No 3 Proba 24b. Were autop prior to comdeath? 1 Yes 2	Day Year a cause of death? bly 4 Denknown sy findings available pletion of cause of Down
Lusée. Enter Underfying at initiated events sulting in death) Last C	e of pregnancy 2 Fetal death 3 Ectopic preg tit time of death 5 Other (spec	26. Place of Death (1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No.	Month I use contribute to the I No 3 Proba 24b. Were autop prior to comdeath? 1 Yes 2	Day Year Pacause of death? Packnown Sy findings available pletion of cause of Common Commo
Living in death) Last C. Due to (or as d. Due to (or as sulfing in death) Last C. Due to (or as d. Due to	of pregnancy 2 Fetal death 3 Ectopic pregnancy 5 Other (spectout not resulting in the underlying cause) Fetal death 5 Other (spectout not resulting in the underlying cause) Fetal death Fetal d	26. Place of Death (Other: 4 \(\text{Nursing Hom.} \) Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \)	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No. Check only one) 5 Residence d. Describe how inju	Month I use contribute to the I No 3 Proba 24b. Were autopyrior to comdeath? 1 Ves 2 6 Other (Specify) Iny occurred	Day Year e cause of death? ably 4 Anknown sy findings available pletion of cause of 2 No
Lives Enter Underlying at initiated events sulting in death) Last C	e of pregnancy 2 Fetal death 3 Ectopic pregnancy 2 Fetal death 5 Other (special death	26. Place of Death (Other: 4 \(\text{Nursing Home} \) 1 \(\text{Yes} \) 2 \(\text{No} \) Office 28	24a. Was an autopsy performed? 1 Yes 2 2 No. Check only one) 5 Residence d. Describe how inju	Month I use contribute to the I No 3 Proba 24b. Were autopprior to comdeath? 1 Yes 26 Other (Specify) by occurred	Day Year a cause of death? ably 4 Anknown sy findings available pletion of cause of 2 No Route Number,
Assessed to the first sale of the first sulfing in death) Last C. Due to (or as d. Due to	ent 2 ER/Outpatient 3 DOA Lify Year) 28b. Time of linjury M 28ctopic preg 20ther (spec 20ther	26. Place of Death (Other: 4 \(\text{Nursing Home} \) 1. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \) Office 28	24a. Was an autopsy performed? 1 Yes 2 No. Check only one) 5 Residence d. Describe how injuited. Location (Street a. City or Town, State and the seven of the se	Month Use contribute to the No 3 Proba 24b. Were autop prior to com death? 1 Yes 2 6 Other (Specify) In occurred	Day Year a cause of death? ably 4 Monknown sy findings available pletion of cause of No Route Number,
A case referred to medical examiner? Manner of Death Deat	ent 2 ER/Outpatient 3 DOA 2 Security M 2 ER/Outpatient 3 DOA 28b. Time of 28c Injury M 28b. Time of 28c Injury M 28c. L 3 DOA 28c. L 3 Ectopic preg 29c. L	26. Place of Death (Other: 4 Nursing Home: Injury at Work? 1 Yes 2 No office 28	24a. Was an autopsy performed? 1 Yes 2 No. Check only one) 5 Residence d. Describe how injuit. Location (Street an City or Town, State d due to the cause(s at the time, date an	Month Use contribute to the No 3 Proba 24b. Were autop prior to com death? 1 Yes 2 6 Other (Specify) In occurred	Day Year a cause of death? ably 4 Anknown sy findings available pletion of cause of No Route Number, ted. the cause(s)
Assessed to pregnant in the past 12 months? Compared to pregnant in the past 12 months? 1	e of pregnancy 2	26. Place of Death (Other: 4 \(\text{Nursing Home} \) Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \) Office 28 the time, date and place, an my opinion, death occurred	24a. Was an autopsy performed? 1 Yes 2 No. Check only one) 5 Residence d. Describe how injuing. If. Location (Street a. City or Town, State at the time, date an	Month use contribute to the No 3 Proba 24b. Were autop prior to come death? 1 Yes 2 6 Other (Specify) by occurred and Number or Rural a) and manner as stadd place, and due to the signed (Month, Distribution)	Day Year Day Year Day Year Day Year Day Year Day Year Day Year
Less Enter Underlying was a listed events at initiated events sulting in death) Last EFEMALE: b. Was decedent pregnant in the past 12 months? 1	e of pregnancy 2	26. Place of Death (Other: 4 Nursing Home: Injury at Work? 1 Yes 2 No office 28	24a. Was an autopsy performed? 1 Yes 2 No. Check only one) 5 Residence d. Describe how injuing. If. Location (Street a. City or Town, State at the time, date an	Month use contribute to the No 3 Proba 24b. Were autop prior to come death? 1 Yes 2 6 Other (Specify) by occurred and Number or Rural a) and manner as stadd place, and due to the signed (Month, Distribution)	Day Year a cause of death? ably 4 Donknown sy findings available pletion of cause of No Route Number, ted. the cause(s)

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1:45 Month Day **Physician** Deloris Kathryn Kestner 5 3 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Inder 1 Year | If Under 24 Hrs. Franklin Square Hospital Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Hours Months 1 □ M 2√2 F 79 Director 098-18-9033 Pennsylvania Auq. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County show item 27 is marked other than "netural", or items 23a or 28e-1 shov other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 U.S.A. 13207 Gundale Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes **2/X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Kestner, Deloris Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. þ 3 Vidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be Patience Sarah Hickson Bruce Hendershot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trau QDGs. 13222 Eastern Avenue, Baltimore, Maryland 21220 Mark Kestner (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard, May 6,2005 Baltimore, Maryland 21. Sloval us of Fun. at Save Licensee 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea or condition resulting in death) Physician Due to (or an consequence of): heart 10 yrs /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate the IF FEMALE: esu. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 0 in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ pe respiratory Failure 1 Yes 2 No 3 Probably 4 Unknown Completed Obstructive pulmonary disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate Coronary 0
25. Was case referred to Godical examiner? artery disease Division of Vital To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No ဥ funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical 29d. Date ned (Month, Day, Year) 29c. License number 29b. Signature and title certif 400520024 Maz V. son who completed cause of death (Item 23a) (Type, Print) 30. Name and addres of pe

State Registrar

Deloris

Box 68760

P.O.

DHMH 17 Rev 1/2001

ORIGINAL

Elecu & Sparle

32. Registrar's Signature

AHMED

31. Date filed (Month, Day Year)

9000 FRANKLIN SQUARE DRIVE, BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4b. City, Town, or Location of Death aomi Ma 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death nossville Blvd MOQ If Under 24 MORE 5. Social Security yrs. last birthday) If Under 9. Birthplace (State or Foreign Country) MARYLAN **Funeral** Days 1□M 20 F Months Min. Hours 212-22-1415 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "netural", or items 23e or 28e-1 ehow other traumatic event, the Mcdical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 21236 14. Race - American Indian, Black, White, etc. DV KE Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity Specify: White. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working hife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Is marked V ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth I 3700 205 Location - City or Town, State 30n J. Westpor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Important: If It eny Injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) who wan Ch. Com. 15-6-05 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BALTINORE, MO 21234 CHAPEL XXXXHARLFORDRO EVANS FUNERAL 23a. Part1. Enter the disease, d shock, or hear failure. Lis eath. Do not enter the mode of dying, such as cardial oproximate iter al Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lease and Lease Examiner Due to (or as a consequence of). The law requires that the death certificate be executed use as the burial-trans the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown cete has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed certificete has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 1 🗌 Yes 2 🗆 No 1 🗌 Yes fo the Hospitel or Attending Physician: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner' Hospital: Other: Certification; To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatu 29c. License number ed (Month, Day, Year) 8

Registrar
DHMH 17 Rev 1/2001

State

			State of Maryland / Department of Health and M State Certificate of Death		ene 2 0 0 5	15392
			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physicia /Medic		WALTER FRANCIS KOSYJANA	Month Y	Day Year 9Y 4, 200	5 8:15A M
	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death Tows	on	4c. County of Deat $\mathbb{B} = 1$	n timore
	Funeral Director			8. Date of Birth (Month, Day, Y September	ear) Co	hplace (State or Foreign Juntry) Tryland
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary 9-f sh	tor	Maryland Baltimore Baltimore			1 □ Yes 2 □ No XXX
	th the	Jirec	10e. Street and Number 10f. Zip Code	100	. Citizen of What Co	
	s 23e	rail	134 Murdock Road 21212		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Modical Examinet must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married XIX Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
9	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	. 16	b. Kind of Business/	Industry
215	ithin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of worki life. DO NOT use retired)	ing	U S Post	Offico
2	filed w Hygier ther ti	CO	2 Branch Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma		, orrice
Maryland 21215-0036	Jental Jental Jerked o	To Be		ne Cakwa	,	
Mary	2 should and Men is marke	V. 1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19c. Mailing Address (Street and Number or Rural			
Itimore, N	1 and Health am 27 ther ti		Bernadette M Kosyjana Wife 134 Murdock Road Balti 20a. Method of Disposition (Name of Dispos	The second secon	C. Location - City or	
	Pages nent of I int: If its iry or o		1 🗖 Burial 2 □ Cremation 3 □ Removal from State 1 ☐ Burial 2 □ Cremation 3 □ Removal from State 1 ☐ Dulaney Valley Mem Gar 5/7/		imonium, M	
Balti	permit. F Departme Importar any injur		21. Manature of Funeral Service Licensee 22. Name and Address of Facility Mit		efeld Funera Limore, Mary	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.			Approximate Interval Between
E	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. PROBABLE DRUG INDUCED HEPATI* Due to (or as a consequence of):			Onset and Death 4 WEEKS
	Examiner		PULMONARY INFILTRATION			5 MONTHS
	ad sit	iner	Cause. Cheer Underlying Cause (Disease or injury Cause (Disease or injury Cause (Disease or injury Cause (Disease or injury)			
ď.	cate be executed physician and the burial-transit	Examiner	c. CHRONIC LYMPHOCYTIC EUKEMIA Due to (or as a consequence of):			5 YEARS
8760	ate be hysicia the bur	dical	d			
Box 6	leath certific attending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of deli	ivery Day Year
o.	that the dec ed by the a detached fo	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 U			
0	Se G	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE	23e. Did toba	6.0	the cause of death?
Records,	law requiras as been si 2 should l	Completed		24a. Was an	24b. Were au	topsy findings available completion of cause of
	i cien : The lav certificate has rector, page 2	Com		autopsy performe 1 Yes 2	d2 death? No 1 ☐ Yes	22 No
Viital	icien: certific ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital: 25 FB/Outbationt 25 Cond. Other: 45 Notice to the conditional t			
on of	ling Phys	ion: To	27. Manner of Death 1 X Natural 5 Pending 28a. Tate of Injury (Month, Day Year) 1 Injury 28b. Time of 28c. Injury at Work?	me 5 Residence 28d. Describe how	e 6 ☐Other (Specinjury occurred	cify)
Division of	or Attand after death Diractor: /	Certification:	2 Suiside 6 Could not be	28f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
	To the Hospital or Attanding Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) Wedicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the To the comple	Me	29b. Signature and the of certifier 29c. License number	29d	. Date signed (Monti	n, Day, Year)
)	<		Parameter D 25569		5/4/0	5
2	D		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	∨ [⊘] Sta	te.	31. Date filed (Monit), Day, Year) 32. Registrar's Signature	N MARYLI	AND SIZE	4
×	Registr		31. Date filed (Month, Day, Year) 32. Date filed (Month, Day, Year) 32. Date filed (Month, Day, Year)			

			1 - For State Registrar	State of N	Maryland / I		irtment of Ho		d Mental Hy	giene Reg. No.	005	153	93
	Physici	an	1. Decedent's Name (First, Middle, Las	_					2. Date of De Month	Day		3. Time of	
	/Medic Examin	cal	AARES LYLE 4a. Facility Name (If not institution, give street and number) MERCY HOSPITAL BACTIME						/-				
	Funeral Director		5. Social Security Number 6. S 214-76-7306 1 Usual Residence of Decedent	9X M 2□F	Age (In yrs. last bii 45	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Ain. (Month, Da	th y, Year) 9. Birthplace (State or Foreign Country) 0,1960 Maryland			
	/land		10a. State 10b. County		10c. City, Tow	m or Lo	cation					10d. Inside Ci	ty Limits
	a-fsh	ctor	Maryland N/A		Bal	tin	ore					XXYes	2 🗌 No
	th with the 23a or 28	al Dire	10e. Street and Number 1529 Mountmoor	Ct.			10f. Zip Code 2121	7		-	zen of What Cou USA	ntry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Hauth and Mental Hygiene Importants if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Marchal Exattring must be notified at once.	Completed by Funeral Directo	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2. If Yes, Give Year or Dates	s? ⊒No		Vas Decedent of His Yes, specify Cubar ☐ Yes 2X No	spanic Origin? n, Mexican, Pi Specify:	? (Specify Yes or No uerto Rican, etc.)		14. Race - Ameri Black, White, Specify:USA		
215-0036	72 ho	eted	15, Decedent's Ec (Specify only highest gra	ucation de completed)	16a	. Deced	lent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of	working	16b. Kir	nd of Business/Ir	dustry	
121	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4c	or 5+)					Pri	vate I	ndusti	rv
d 21	filed within Hygiene.		10th grade 17. Father's Name (First, Middle, Last)			Cc	nstruct		Orker Name <i>(First, Middle</i>			iaab e.	
lan.	Aental Aental rked c	To Be	James A. Lyle,	Sr.				Cele	stea Mad	dden			
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type, Print)	19t	o. Mailin	g Address (Street a	nd Number o	r Rural Route Numb	er, City or	r Town, State, Zij	Code)	
	m 27		<u> Fiesha J. Lyle</u>	/Daught			Mountmo		. Baltir				21217
Baltimore	Pages 1 Iment of H Iant: If Ita jury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	<i>'</i>)	te Voshe	T I	Memoria Memoria		5/65 dens	Dun	dalk, Ma	aryla	
Ball	permit. Departr Importa any inju		21. Signature of Juneral Service Uter	See					Chatman own Rd 1				
			23a. Part I. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each	sed the death. Do		er the mode of dying				IMOLE,	Approximat Interval Bet Onset and	e waen
	Pnysician /Medical Examiner		disease or condition resulting in death)	a	as a consequence							6 8	795
7	D tis	lner	Sequentially list conditions, if any, leading to immediate naise Enter Indanying Cause (Disease or injury										
V	sate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a consequence	of):					-		
8760,	physicist the bu	dlcal		. d									
O. Box 6	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		2 Fetal death at time of death		Ectopic pregnancy Other (specify)			2	23d. Date of deliv Month	-	Year
ds, P.O.	gn gn		Part II. Other significant conditions of Pent Tre Class	ontributing to death		in the ur	nderlying cause give	n in Part I.		Yes 2	se contribute to t	he cause of d	
00	s been si should!	olete	chronic re	wal fr	ALLRE				24a. Was		24b. Were auto	psy findings	available
Vital Records,	rsician: The law s certificate has b lirector, page 2 s	Completed by	Aate Myoca	edial in	farction)			1 ☐ Yes	ormed? 280 No	prior to co death? 1 \(\sum \text{Yes}	mpletion of c	ause of
V.	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	atient 2 ER/O	utnatien	Othe		Death (Check only only only only only only only only		S ∏Other (Speci	f _V)	
ion of	ting After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of It (Month, I	njury 28b.	Time of Injury	28c. Injury Work	at	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	To tha Hospital or Attendi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of	Injury - At home, for etc. (Specify)	arm, str	eet, factory, office		28f. Location (City or To		d Number or Run)	al Route Num	ber,
	To the Hospital within 24 hours of To the Funeral Completely filled	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basis and manner	of examination ar	e, death	occurred at the tim restigation, in my op	e, date and pi inion, death o	lace, and due to the occurred at the time,	cause(s) date and	and manner as s place, and due t	stated. o the cause(s	:)
	within To th	M	29b. Signature and title of certifier	SAM	40		29c. License	number		A	e signed (Month,		-
	4		30. Name and address of person who	completed cause o		DA	UN PLAZ	E B	ALTIN 526	140	212	2	
	Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature								
DH	Registi MH 17 Rev 1/2	-	MA	7 0 6 2005	Mesera	0 1	4 Speed						

ORIGINAL

		_	State of N	1arylan		artment rtificate			d Mental	Hygien	Com C C 1	Ö	15394	
	Physicia		Decedent's Name (First, Middle, Last) JUNE	D.	LUMBY				2. Date Monti MA	of Death	² 2005	aer	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give street and number BLAKEHURST CARE CENTER)	'		4b. City, 1		ocation of D			c. County of D			_
	Funeral Director		360-05-4888 1□ M XX F	ge (In yrs. I	last birthday) Yrs.	If Under Months		If Under 24 I Hours N	Hrs. 8. Date (Mont	of Birth h, Day, Yea 08-19	9.	Birthplace Country MISS	ce (State or Foreign) OUR I	
	show	20	Usual Residence of Decedent 10a. State 10b. County MD. BALTIMORE	10c. City	y, Town or Lo		TOWSO)N				10d	. Inside City Limits 1 ☐ Yes 2\(\)\(\)\(\)\(\)\(\)	_
	vith the M r or 28e-1 be notifi	Director	10e. Street and Number 1055 WEST JOPPA ROA	D		10f. Zip				10g. C	Citizen of Wha		/?	
36	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28e-f show that the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married	nt Ever in U.		Was Deceded of Yes, special	ent of Hisp ify Cuban,		? (Specify Yes uerto Rican, etc	or No- c.)	14. Race - /		2.	_
21215-0036	within 72 hour iene. r than "natural tre Medical Ev	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c) 4 YEARS	r 5+)	(Giva	DO NOT us	k done du	ring most of	working		Kind of Busin	ess/Indus	stry	
Maryland 2	b d at a	To Be C	17. Father's Name (First, Middle, Last) PAUL J.	DESCH	ER		1		Name (First, M ILA	iddle, Maide (UNKN)				
	D = =		19a. Informant's Name/Relationship (Type, Print) ROBERT W. LUMBY (HUSBAN	ID)		-			r Rural Route ^ D,TOWS					
Baltimore,	Pages nent ol ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 (D)Cremation 3 ☐ Removal from Sta 1 ☐ Donation 5 ☐ Other (Specify)		Place of Disponentery, created by LLTOP	matory or ot	her place)		Date 5-07-20		Location - City NSON, MA		n, State ND, 21204	
Balti	permit. Pages Department of Importent: If it eny injury or c		21. Signature of Funeral Service Licensee			2. Name and		•	RAL HOM	E,INC		YOR SON,M	K ROAD D.21204	
8760,	Physician /Medical Examiner potansit fundamental po	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events c.	ed the death line. 2 / Cas as a consequence as a consequence as a consequence	uence of):				adiac or respirat			> In	pproximate therval Batween therval Batween therval Batween the constant of the	
P.O. Box 687	ne death certificate the attending phy hed for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes XX No 9 □ Unknown	2 Fetal	I death 3	□Ectopic pre					23d. Date of Month	f delivery Da		The second of the least of the
	uires that the signed by Id be detac	þ	Part II. Other significant conditions contributing to deat	but not res	ulting in the u	Inderlying ca	use given	in Part I.	23e.	Did tobacco	_	te to the	cause of death?	/
Il Recor	sicien: The law requir s certificate has been si lirector, page 2 should	Completed							24a.	Was an autopsy performed?	' deat	re autopsy r to comp th? Yes 2(y findings available letion of cause of	_
Division of Vital Records,	ftei	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 Nanner of Death X Natural 5 Pending (Month, 1) 2 Accident investigation		ER/Outpatie 28b. Time o Injury		Other: 3c. Injury a Work?	4 🗌 Nursir	Death (Checking Home 5 28d. Desc	Residence	6 XX ther (a	Specify)	CARE CENTER	
Divisi	of or Atten efter deal Directoral	Certification;	3 Suicide 6 Could not be 28e. Place of	Injury - At ho etc. (Specif	ome, farm, st y)	reet, factory	, office			tion (Street or Town, Sta	and Number o	or Rural R	Route Number,	
	To the Hospitel or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	of examina	owledge, deat	th occurred a vestigation,	at the time in my opir	, date and p	lace, and due to	o the cause time, date a	(s) and manne and place, and	er as state due to th	ad. ne cause(s)	-
	To the To the comp	Me	29b. Signature and title of Certifier			290	License i	numicer 7-8	3	29d. [AY 5,	Nonth, Da		
_	4		30. Name and address of person who completed cause of Joseph Johns,	MO	(St., To	owson,	Md. 2	1204		
	Sta Regista			strar's Signa	ature	t)								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** VIVINHOD LEE MOUXON 05.02. 5:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SPRINGBROOK REHAB SILVER SRING 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) 1 1 M M 2 □ F 217.52.4993 Director Usual Residence of Decedent s should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits JESSUP 1 ☐ Yes 2 No MD HOWARD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WYE 20794 1316 AVENUE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ?? is marked other than "naturel", or itams treumatic event, I'm Modical Exercitor 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1,4or 5+) INVENTIORY CLERK GIANT FOOD INC. 1214 GRADE N A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROSE CHARLES HENRY MOUZON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other treu <u>once</u>. 1316 WYE AVE. JESSUP MD 20794 HENRY MOUZON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05.06.05 ELKRIDGE * 4 ☐ Donation 5 ☐ Other (Specify) MEADOW RIDGE VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licenses angh 5151 BALTO. NATE PIKE, BALTO. MID 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helm failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mccphalopathy /Medical Due to (or as a consequence of) Examiner Virus Intection Immunodeficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be exacuted Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown by signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tallure 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy performed/ 2120 certificate 2□ No 25. Was case referred to medical 1 Yes 2 No 1 TYes the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 Tes 2 No 2 Accident investigation Diractor: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 26564 -dr 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) 3 418 Wash SE 106 Irvino # 20010 Register's Signature 31. Date filed (Month, Day. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3:00 RISTINE ANN MUSSELMAN 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death RALTIMORE ESSEX IRCLE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Days Min 1 ☐ M 2 🗷 F Months Hours 213:64.0254 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No SALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22 .5.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes. Give 1 Yes 2 No Specify. Specify: WhITE If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMINISTRATIVE ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STANLEY CHARLES UDES SR. ATHERINE STENAEL 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - C ANTHONY MUSSELMAN, HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State VIEW CREMATORY MALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fundal Service 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD 21122 Part1. Enter the disease, or por plicatio and the use if shock, or heart failure. List only one cause on each line. Approximate Interval Between Onserand Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final lung cell disease or condition resulting in death) Small 1 year Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 🗆 No 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident Accident

The law requires that the death certificate be executed as the burial-transit attending physician and for P.O. P the certificate has been signed by Division of Vital Records, director, page 2 this filled in by the funeral . After I or Attending death. after death 24 hours a

Physician

/Medical

Examiner

Funeral

Director

28e-f show

rel', or items 23s or 28e-f show

"naturel",

marked other then

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 le rr eny injury or other traum once.

Physician

/Medical

Examiner

2 should be fi and Mental H

other traumetic event, It e Medical

Directo

Completed by Funeral

Be

with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Was case referred to medical examiner? ဥ 1 🗌 Yes 27. Manner of Death Certification: 1 Natural 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier Medical completely

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

03525 BALTMONEME Caton ave

State Registrar

arole Mille 31. Date filed (Month, Day, Year) 32. Registra Signature MAY 0 6 2009

9005

To the To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene: 🔱 🕕 🖔 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 12:39 PM Bonnie Miller Ma 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Carter Baltimore University If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 213-60-7448 Months 1□M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21090 U,5.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: þ MITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MAYNARDC. ShIFFLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. In ormant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cometery, crematory or other place) MD. 21090 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyn Sprvice Lice See 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 or commentations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. I Approximate Interval Between Onset and Death mmediate Cause (Final multiforme alioblastoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of).

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

, or Items 23e or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural, or Items 23e any injury or other treumetic event. The Medical Exercised Principle.

Baltimore, Maryland 21215-0036

the Medical Examinat must be notified at

Directo

Completed

Be

the Maryland

the burial-transit igned by the attending physician and be detached for use as the burial-trar filled in by the within 24 hours a
To the Funerel C
completely filled

or Attending Physicien: The law requires that the death certificate be executed

signed by

After

after death.

Hospitel

To the

Division of Vital Records, P.O. Box 68760,

ner Certification

Medical

Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1□Live birth 2□Fetal d 4□Pregnant at time of dea 9□Unknown	eath 3 ☐ Ectopic pregnancy
Part II. Other significant condition	s contributing to death but not resulti	ing in the underlying cause given in Part I
25. Was case referred to medical examiner?		26. Place
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 EF	R/Outpatient 3 DOA Other: 4 Nu
27. Manner of Death	28a. Date of Injury 2	8b. Time of 28c. Injury at

ic pregnancy r (specify)

23d. Date of delivery Month

	23e. Did toba	cco use cor	tribute to the cau	ise of death?
	1 ☐ Yes	2 No	3 Probably	4 🗌 Unkno
ļ				

Year

24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 20 No 1 ☐ Yes 2 No 1 ☐ Yes

04,

2005

26	. Place of Di	eath (Ci	neck only one)	
ther:	4 🗌 Nursing	Home	5 Residence	6 ☐Other (Specify)
ury at			Describe how inj	

28c. in

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death o 2 Medical Exeminer: On the basis of examination and/or investand manner stated. 29b. Signature and title of certifier P177 35 MD

29d, Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who com pleted cause of death (Item 23a) (Type, Print)

> South Greene St., Baltimore 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

5 Pending investigation

6 Could not be

determined

2 Accident

4 Homicide

31. Date filed (Month, Day, Year)

3 🗌 Suicide

29a. Certifier



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Daniel Marucci State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
1- State of Maryland / Department of Health and Mental Hygiene
Certificate of Death tas Reg. No.

Reg. No. 05-3049 AKG Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Daniel Marucci 2005 May 4:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Rosedale Baltimore County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

NOV. 17, 1949 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□ F Yrs. Director 55 222-34-1311 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show r then "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2No Completed by Funeral Director Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 Homberg Avenue U.S.A.

14. Race - American Indian,
Black, White, etc. 21221 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽQNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other then "natural", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Specify 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Counselor 4 Drug and Alcohol treumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Francis Marucci, Sr. 2 Grace Gebheart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Daniel Evans (Son) 300 Mary Street, Wilmington, Delaware 19804 other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Wilmington, Delaware Pages 5-9-05 * <u>=</u> Burial 2 remation 3 Removal from State AllerSalfitstoCemetery ō Department of Importent: If eny injury or once. 4 □Donation 5 □ Other (Specify) Bayview Crematory 05/07/2005 Paltimere, Maryland 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21-Signature | Fune al Prince Licensee 1407 Old Eastern Avenue, Essex, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Methadone Intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Physician/Medical Examiner sician and a burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f o م signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Vital Yes 2 No 2 No AS the Hospitel or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of **unk** 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred unk Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 X No 2 Accident investigation 5-2-05 after death Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 214 Homberg Ave., ģ 4 Homicide Home Baltimore, MD within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onh 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) OCME May 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 MI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State WAY O 6 ZUUS Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Day **Physician** Ronald Miller John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 7. Age (In yrs. last birthday) HAVre-de-Grace Harford Memorial Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nav 12, 1929 Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 16 M 2 □ F 18-26-6409 Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show other traumatic event. The Medical Examiner must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Bel-AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronics Technician Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be if Health and Mental litam 27 is marked o Miller Harry Melvin Mary Elizabeth Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Rosalie M. Miller - Wife 1413 Beacon Court Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō = 6 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Hilltop Service Corp May 9,2005 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 22. Name and Address of Facility Baltimore, Maryland 21214 21. Signature Fy eral Service License Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio- respiratory Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a nonsecuence of Certification; To Be Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 THomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fun completely t 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0002534

Registrar DHMH 17 Rev 1/2001

State

Registrar's Signature

HOURER Grace Mel - 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIS KEHIEL.

MAY 0 6 2005

31. Date filed (Month, Day, Year)

		For State Registrar	State of		•			nd Mental		-21% etc	1 7/00
			Last) Morris						of Death		3. Time of Death 3:08A. M
					4b						
Physician December Sweet Pieze Motion, Lact) Physician December Sweet Pieze Motion, Lact) Physician Ph				14							
ryland how	_			10c. City, Town	or Location	on					10d. Inside City Limits
the Ma 28a-f s	ecto		VA.	B					100 (Citizen of Milat Co.	1X Yes 2 □ No
with 3a or	ij		ıo.		- [20		log. (antry?
<u> </u>		11. Marital Status 1 X Never Married 2 Marrie	12. Was Deced Armed Forced 1 Tyes 2	es? X) No	If Ye	s Decedent of His es, specify Cubar	spanic Origi n, Mexican,	in? (Specify Yes of Puerto Rican, etc.	or No-	14. Race - Amer Black, White	, etc.
within 72 hou sine. Than "nature it would all it.	ompieted	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(6)	Give kind fe. DO l	d of work done d NOT use retired)	urina most	of working		Kind of Business/li	ndustry
id be filed ental Hygi ked other ic event, I	Be	17. Father's Name (First, Middle, L	ast)		<i>D</i> .				ddle, Maide		
MICHY 12 shou h and M 7 is mar traumat	-	19a. Informant's Name/Relationsh			-		nd Number	or Rural Route N	umber, City		ip Code)
ther there		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from St	20b. Place of D cemetery,	isposition cremato	on (Name of ory or other place	9)	Date	20c.	Location - City or T	own, State
Dailti permit. F Departme Importar any injur				Arbucus	22. Na	ame and Address	s of Facility				ore MD 21217
Examiner	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
the death certificat the attending phy ched for use as th		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birt 4 ☐ Pregnar	h 2 🗋 Fetal death nt at time of death							rery Day Year
quires that n signed by aid be deta		Part II. Other significant condition	ns contributing to dea	th but not resulting in th	ne under	rlying cause give	n in Part I.				
<u> </u>								\	autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
ding Phys h. After this	0	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	28a. Date of (Month, ation Fuel 5	Injury 28b. Time Injury 105 Fund 105 Fu	ne of iry 2:37	26. Place of Death (Check only one) tient 3 DOA Cther: 4 Nursing Home 5 Residence 6 0 e of 28c. Injury at Work? 21:3 M 1 Yes 2 KNo Subject Su					
Hospita 4 hours Funeral	edicai C	29a. Certifier 1 Certifying (Check only one)	Physician: To the b xaminer: On the bas and manne	est of my knowledge, of is of examination and/o	leath occ	curred at the time	e, date and inion, death	place, and due to	the cause(s) and manner as and place, and due to	stated,
To tha within 2 To the comple	Me	29b. Signature and title of certifier Zaly zul	ial A	4-			number ME			ate signed (Month,	
, T		30. Name and address of person w	no completed cause	of death (Item 23a) (Ty	pe, Prin	111 Penn	Stre	et Balt		, Maryla	
Stat Registra		31. Date filed (Month, Day, Year) - MAY 0	6 2005 ^{32.} 3	istrar's Signature	for	de					7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma		artment of Health and rtificate of Death			
			Decedent's Name (First, Middle, La	st)			2. Date of Death	. No. 2005	3. Time of Death
Į.	Physici /Medio			<i>Aason</i>			Month 5	Day Year	ilico am
	Examir	er	4a. Facility Name (If not institution, giv			4b. City, Town, or Location of Dea		4c. County of Dear	
			University of Mar 5. Social Security Number 6.5			Baltimore Huder 24 He		MARY	
	Funeral Director		203-36-44/4	M 2□F	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Ye	ear) 9. Birt	thplace (State or Foreign buntry)
	D		Usual Residence of Decedent				NOV 24,1	996 TEX	UNSYLVANIA
	show		10a. State 10b. County		10c. City, Town or Lo				10d. Inside City Limits
	8a-f	ecto		ANON	Mye	rs to www			1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number		Avenue		10g.	. Citizen of What Co	•
	ns 23	Funeral Director	11. Marital Status	12. Was Decedent B			Coopie Van as Na	U.5.A	
9	after o		1 Never Married 2 Married	Armed Forces?	0	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Ame Black, White	e, etc.
8	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show dical Examirat Le notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		Specify: U	hite
7	72 h "netu	Completed	15. Decedent's Ed (Specify onfy highest gra	lucation de completed)	(Give	dent's Usual Occupation kind of work done during most of wo	orkina 16t	. Kind of Business/	Industry
12	filed within Hygiene. Ither then "	mp	Elementary/Secondary (0-12)	College (1-4or 5	+) ife.	DO NOT use retired)		Educi	and ind
9	e filed v al Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	4	1111	gRADE SCIENCE	TEACHER me (First, Middle, Maio		TITON
Maryland 21215-0036	should be nd Mental marked c	To Be	JOHN	C .	MASO		3		Carlo
ary	shou and N s mar	~	19a Informant's Name/Relationship (Type, Print)	10b Mailie	a Address (Chrost and Mustan B		ity or Town, State, Z	ip Code 17067
	and 2 salth a n 27 ls		MRS. MARY AN	N MASON	Wire 215	W. FRANKLIA sition (Name of natory or other place)	Avenue	MYERS	LOWN. PA
Baltimore,	- I P E		20a. Method of Disposition 1 Surial 2 Cremation 3 C	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date 200	. Location - City or	Town, State
Ĕ	Pages ment of l ant: If it		'4 ☐ Donation 5 ☐ Other (Specify	<i>'</i>)	St. Gertr	natory or other place) MacCathelic May Name and Address of Facility	112,2005 L	EBANOI	N PA
<u>a</u>	permit. Pag Department Important: eny injury o		21. Signature of uneral Service Licen	500	22	Name and Address of Facility	ZANNIN	id LICE	vseid .
	FU = 9 0		Charle.) auno	1.0	り しゃスペングチス しつみ	142 MARY	m) 2120:	3 HERTICIAN
П			23a. Part1. Enter the disease, or confishock, or heart failure. List only	ne cause on each lin	the death. Do not ent e.	er the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myora	rdial Info	retion			Criser and Death
	Examiner			Due to (or as a	consequence of):				
l,	-14-	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):				
	cuted and a	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.					
Ö,	e exe		resulting in death) Last	Due to (or as a	consequence of):				
68760	rtificate be executed on physician and ras the burial-transit	Medical	•	d					
9 X0		/Me	IF FEMALE:	23c. If yes, outcome o	of programmy				
\mathbf{m}	The law requires that the death oe the has been signed by the attendinage 2 should be detached for use	Physiclan/I	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	very Day Year
о. О	the d by the ached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cuter (specify)			
	s that ined to e deta	by P	Part II. Other significant conditions co	ontributing to death but	t not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ğ	w require been sig should b		Ocute renal insuf	frerency on	Chronic re	rul insufficiency	1 ☐ Yes	2 □ No 3 🕱 Pro	bably 4 Unknown
ပ္ပ	law re as be 2 sho	plet	Diubetes Mel			,	24a. Was an	24b. Were aut	opsy findings available
DIVISION Of VITAL Records,	Physicien: The lav this certificate has al director, page 2	Completed					autopsy performed′ 1 Yes 2 X	? death?	ompletion of cause of
<u> </u>	icien: sertific ector.	Be	25. Was case referred to medical examiner?				th (Check only one)		
0	Physical direction	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Ninpatien		3 DOA Other: 4 Nursing H	ome 5 Residence	6 □Other (Speci	fy)
5	ding h. After funer	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	ijury occurred	
2	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, farm, stre		28f. Location (Street	and Number or Pur	al Pouta Number
5	after safter of in the	Certification:	4 Homicide	building, etc.	(Specify)		City or Town, Sta	ate)	arriodie warnber,
	ospit hours unere ly fille		29a. Certifier 1XCertifying Phy	sician: To the best of	my knowledge, death	occurred at the time, date and place	, and due to the cause	(s) and manner as s	stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical	one)	and manner state	skamination and/or inv	estigation, in my opinion, death occu	rred at the time, date a	and place, and due t	o the cause(s)
	To To Com	Σ	29b. Signature and title of certifier		A	29c. License number		Date signed (Month,	Day, Year)
			Acres 10			AU4176435K 1581	69 5	105/05	
	15		30. Name and address of person who c						
	Stat	ė.	Stacy Kennedy, M 31. Date filed (Month, Day, Year)	32. Registrar	's Signature	treet, Baltimor	e, Maryla	nd 2120	1
	Stat	e Ir	MAY 0 6 2	POE S	L 4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 11:00P MAY 2005 annor a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BACT MOIE BALTIMORE 27 5. Social Security Number 6. Sax 12 M 2 ☐ F 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Yrs 216-16 MARYLAND 10-21-Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3802 USA 12. Was Decedent Ev. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Union 55 eamste 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) lhomas araare 19b. Mailing Address (Street and Number or) Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type, Print) 9 20c. Location - City or Town, State Hollow briar Mnita leamon 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Valley Mem Gardens 5-7-05 Timonium, MD 22. Name and Address of Facility BACTI MORE, MD 21234 21. Signature of Funeral Service EVANS FUNELAL CHAPEL 8800 HARFORD RA Simber arottu 23a. Part1. Enter the disease, of complications that cause shock, or heart failure. List only one cause on each li the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LL Due to (or consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown

Pnysician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

ပ

10a. State

Funeral

Director

"natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than '

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or othar trau

Examine Physician/Medical Completed by Be Medical Certification: To

nding physician and use as the burial-translt To the Hospital or Attending Physician: The law requires that the death certificate be executed use as atten for u been signed by the should be detached cete has director After thi within 24 hours after death.

To the Funaral Diractor: A completely filled in by the ft.

State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical

1 🗌 Yes

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

2 No

5 Pending

investigation 6 Could not be determined

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs formed? 2**0**0 No 2 No 1 Yes 1 ☐ Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier mE cen

29c. License number 020396

Blue.

29d. Date signed (Month, Day, Year)

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Hehn Raven 5601

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DLIVER Day Year DUD 12:21 PM ZUUSC /Medical 4a. Facility Name (In not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MIDIN COL JMONS-N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1ÄM 2□F Director 214-40-2440 63 Yrs. 9,1942 Jan. Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits Examiner rate by nutitied at Director 1X Yes 2 No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 121 North Belnord Avenue Itams 23g 21224 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🛛 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Specify: "natural', White Completed Tre Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. itam 27 is marked other than other traumatic evant, it e.m. Elementary/Secondary (0-12) College (1-4or 5+) 9 Yéars Nursing Assistant Health Care Provider 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filk iment of Health and Mental Hitam 27 is marked oth 18. Mother's Name (First, Middle, Maiden Sumame) Be Vernon Oliver 0 Mary Staten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James L. Oliver (Son) 4 Main Sail Ct. Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Removal from State = 5 Department of Important: If any injury or once. Gardens of Faith Cem. □Donation 5 □Other (Specify) 5/5/2005 Rossville, Maryland permit. 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee Inc. 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MIMIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed ERT CNOISINE that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death for in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Completed 1 ☐ Yes 2 ☐ No 3 Probably 42 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 🗆 Yes 2.2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 2 □ No 2 ■ER/Outpatient 3 DOA 1 Inpatient s after des...
sal Director: After...
vv the funeral dir this 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To tha 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIJINA 1) SIFE NORTH 10+1 31. Date filed (Month, Day, Year) egistrar's Signature State MAY 0 6 2005 Registrar

			State of Maryland / Depar			•	
			1_ State	ificate of Death		No.2005	15404
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	. 140.	3. Time of Death
	Physicia		Rose Mary O'Connell		May 5,	2005 Year	12:20A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Death	
1				Severna Park		Anne Aru	ınde1
	Funeral		1□M 202 F	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	 Date of Birth (Month, Day, Y 	ear) 9. Birthp	lace (State or Foreign try)
	Director		217-09-4464 91 Yrs. 91 Yrs.		10/06/1	913	MD
	yland Now		10a. State 10b. County 10c. City, Town or Local	ation		1	Od. Inside City Limits
	a-f st	ctor	MD Anne Arundel Pasadena	a			1 Tyes 2 No
	with the Maryland a or 28a-f show be notified at	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
	ath w	ral	409 Sylview Drive	21122		U.S.A.	
	er de Itam	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto f	city Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
33	urs aft	by F	3 Married 2 Married 1 If Yes, Give 1 € Year or Dates:	☐ Yes 2 🛣 No Specify:		Specify: Whi	te
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or itams 23a or 28a-f show event, the Medical Examinat must be notified at	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kit	nt's Usual Occupation ind of work done during most of working	16	b. Kind of Business/Inc	Justry
7	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)			
7	filed with Hygien that the the	Co		s Associate		upermarke	et
and a	ould be fi Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last) Cusimo Serio	18. Mother's Name	s Broca		
2	should ind Men marke umatic	P		Address (Street and Number or Rura			Code)
_	es 1 and 2 should be of Health and Mental of Health and Mental if Item 27 ie marked o or other treumatic eve			Sylview Drive,			
Baltimore,	s 1 ar		20a. Method of Disposition 20b. Place of Disposit			c. Location - City or To	
Ë	permit. Pages Depertment of h importent: if its any injury or of		1 Burial 2 Ki Cremation 3 Hemoval from State	Crematory 05/0	07/05 B	altimore,	MD
ä	apertri porte iy inju						Home, PA
n —	#9 # 9			9 Riviera Drive	e, Pasa	dena, MD	21122
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	1 -1			Approximate Interval Between Onset and Death
. 4	Pnysician		Immediate Cause (Final disease or condition resulting in death)	eart teulu	a	- /	beach
1	/Medical Examiner		Due to for as a consequence of):			13	/
	10.3	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				1994
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
o,	te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760		licai	d				
X 68	The law requires that the death certifica tle has been signed by the attending ph tage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
Rox	attend for us	sian,	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
o.	by the destached	ysic	1 Yes 2 Mo 9 Unknown	, (apass) /			
J.	res that igned b	by Pł	Part II. Other significant conditions contributing to death but not resulting in the under	lerlying cause given in Part I.	23e. Did tobac	cco use contribute to th	e cause of death?
ğ	w require been sig should b	edk	Renal insufficiency		1 🗆 Yes	2 □ No 3 □ Prob	ably 4 Unknown
ecords,	aw re as ber 2 sho	Completed	Per, pheral vascular	disease	24a. Was an autopsy	24b. Were autop	osy findings available
r		Com			performe 1 ☐ Yes 2 🗹	d2 death?	
Vital	rsician: The law s certificate has t lirector, page 2 s	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0	Physic this cral dir	<u>ا</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Mann Death 28a. Date of Injury 28b. Time of		ne 5 Residence 28d. Describe how	e 6 Other (Specify	")
O	ding F th. After funera	tion	1 atural 5 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 No	.od. Dosoniba now	injury occurred	
Division	Attendi r death. sctor: A by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury : At home, farm, stree	at, factory, office	28f. Location (Stree	at and Number or Rura	l Route Number,
5	s afte	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	state)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only (Ch	occurred at the time, date and place, a	and due to the caus	se(s) and manner as st	ated.
	To the h within 24 To the F complete	Medical	one) and manner stated. 29b Significature and title of certifier	29c. License number		Date signed (Month, I	
	Twit Wil		M M	DS07,	25	5 - 6 -	-0.5
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	nint) /	11/1	11	1)
	2		clennites diedincer 8601 V	eteranstrul/	1. Clersi	ville NI	1021108
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	0		/	
	Registr	ar	MAY 0 6 2005 Santa & South	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#8 per FH 6843.5/1//05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Frank Joseph Pural 9,30 am 05 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square
5. Social Security Number Ba Itimore 1105pital Mose da le enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1927 9. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min Hours 15€M 2 ☐ F Months 216-20-1548 78 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Itame 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8332 Bletzer Road 21222 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? NEWYes 2 □ No if Yes, Give Year or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes → No Specify: 3℃Widowed 4 Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Eastern Stainless Steel Crane Operator 11 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: if Item 27 is marked oth
any Injury or other traumatic even
ange. Be Frank Joseph Pural Lillian Ustach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8902 Philadelphia Road, Baltimore, Maryland 21237 Joann Pural (Daughter) ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus May 7,2005 Baltimore, Maryland 21. Signature of Fire and Sprvice License 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 48 hours /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and s the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by as been signal 051 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4/∑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page tory la paro tomy certificate plora 2 2 No 1 Yes Division of Vital ector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Alnpatient Medical Certification: To 2 ER/Outpatient 3 DOA funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0060576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, Md. 21237 leanette hrolihowski 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

ORIGINAL

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. Amend Item 23a per phys 2843 5-6-05 vt. State of Maryland / Department of Health and Mental Hygiene. Registrar amend item #23ePFR FH C843 Septificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Genevia Pierce April 11:39 PM 25 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 0 Sinci Hespital Baltimore Baltimore Cit If Under 1 Year _ If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 M 2/ F Yrs. Director 72 218-36-2802 SC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MDNΑ Baltimore Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4118 Mountwood Road 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: þ XXWidowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other ther Food Service Worker Public Schools llth grade 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 i Belinda Johnson-Daughter 28 Mardrew Road, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Importent: If iter
eny injury or oth 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State * 4 Donation 5 ☐ Other (Specify) 5/2/05 Druid Ridge Pikesville, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 wabash Ave, Baltimore, Md 21215 23a. Part. Ent., the disease, or comp cations that caused the death. shock, or heart failure. List only on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Adenocarcinoma of lung Approximate Interval Brights Onset and Death'S Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Respiratory distress syndreme 4 days /Medical Due to (or as a consequence o): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 🗌 Uлклоwn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Mellitus Diabetes 1 Tes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy performed? 1 Yes 2 □ No 1 Yes 2 No Hospitel or Attending Physicien: Be (25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES 000 April 25, 2005 Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VISHNUPRIYA, KITTANE 2401 West Belvedeve Avenue Baltimore MD 21215

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 6 2005

J

Knowsn

32. Resstrar's Signature

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

10a. State

MD

10e. Street and Number

215-24-0369 Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

NA

TENERO

1 □ M 2√2 F

6. Sex

Physician

/Medical

Examiner

Director

Funeral

Director

7 is marked other then "natural", or Items 23s or 28s-f show treumstic event, the Medical Examinar must be notified at Street Apt 810 West Conway Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🂢 No Specify: Specify: þ XXWidowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) House Homemaker 10th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida L. Jones ပ John McNair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Importent: If Item 27 is
any Injury or other treu 8401 Allenswood Road, Balto., Md 21216 Deborah Fortson-Cousin Baltimoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/6/05 Baltimore, Md * 4 ☐ Donation 5 ☐ Other (Specify) Western Star 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lease or condition sulting in death) Physician Metastah ancreahc C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, loading to infinited late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9□ Unknown 9 ☐ Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performs 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Ne te of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospitel o within 24 hours aff To the Funerel Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20109 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signature 31. Date filed (Month, Day, Year) S'ate Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Virginia

7. Age (In yrs. last birthday)

76

Yrs.

10c. City, Town or Location

Baltimore

Certificate of Death

10f. Zin Code

Pinchback

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days)

Nonths Days Hours Min. 11 25

4b. City, Town, or Locetion of Death

21201

Reg. No.

Year)

2. Date of Death

Mac

3. Time of Death

00

Birthplace (State or Foreign Country)
 MD

10d. Inside City Limits

1 Yes 2 No

5

4c. County of Death

10g. Citizen of What Country?

U.S.A.

ORIGINAL

		1 - For State Registrar	State of	f Marylan		artment o			lental Hy	giene Reg. No.	00	5	154	0.8
Dhusisi		1. Decedent's Name (First, Middle, Las	it)						2. Date of De Month	ath Day	Y	ear ear	3. Time of	Death
Physici /Medic		Eleanor Wh:	Ltacre I	Pinion					May 3				10:50	A ^M
Examin		4a. Facility Name (If not institution, give		n <i>ber)</i>		4b. City, Tow	m, or Location	n of Death		4c. C	ounty of	Death		
		7319 Bradley Boul				Bethe		24 04 14				mery		
Funeral		5. Social Security Number 6. S 076-05-0611	9X □M 20 X]F	7. Age (In yrs 89	last birthday) Yrs.	If Under 1 Ye Months Da	ays Hours	er 24 Hrs. Min.	8. Date of Bird (Month, Da	y, Year)	, = 9		ace (State o	r Foreign
Director		Usual Residence of Decedent		09					Sept. 1	/, 19	15	New	York	
land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10	d. Inside Ci	ity Limits
Man Man	tor	Maryland Montgome	ery		Bethes	da							1 🗌 Yes	2 No
h the	irec	10e. Street and Number				10f. Zip Cod	de			10g. Citize	on of Wh	at Count	ry?	
23a c	a D	7319 Bradley Boul	evard			208	17			Un	ited	Sta	tes	
ams ams	Funeral Directo	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13.	Was Decedent If Yes, specify (of Hispanic (Cuban, Mexic	Origin? (Span, Puerto	ecify Yes or No Rican, etc.)	- 14		America White, e	an Indian,	
or It	Y.F.	1 ☐ Never Married 2 Married	1 ☐ Yes tf Yes, Giv	9		1 □ Yes 2 🔯					Specify:		nite	
ural,	d by	3 Widowed 4 Divorced	Year or Da	ates:	1 150 Dane	dent's Usual Od				105 100	d of Duci			
"nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of work do DO NOT use re	one durina m	ost of work	ing	16b. Kine	or Busi	ness/ind	ustry	
withi ene. than	ᇤ	Elementary/Secondary (0-12)	College (1	-4or 5+)		Homemak	er			,	Own	Home		
filed Hygi othar ant.		17. Father's Name (First, Middle, Last)						ther's Name	e (First, Middle,					
lid be ental kad kad ic av	To Be	Lewis F. Whitacı	:e				H	laze1	Hampton	n				
shou and M mar umat	-	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Str			al Route Numbe		Town, St	ate, Zip	Code)	
alth a alth a 27 lg		Jack A. Pinion /	Husband	1	7319 I	Bradley	Boule	vard.	Betheso	la. M	arv1	and	2081	7
of He of He litam		20a. Method of Disposition	Dameural from 1	1 ^	lace of Dispo	sition (Name o	place)		Date	20c. Loc				
Page ment: If ant: If ury o		1 ☐ Burial 2 ☒ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	/)	State	Mon	tgomery torium,	Inc.	20	05	Ве	thes	da,	Mary1	and
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Health and Mental Hygiene. Depurtment of Health and Mental Hygiene. Important: If its marked other than "natural", or Itsms 23a or 28a-f show any injury or other traumatic avant. Its Markeal Exament ritist be indiffed at once.		21. Signature of Funeral Service Uper	W>	M0142	Ro R	2. Name and Acobert A.	ddress of Fac Pumphre	ey Fun	eral Home Bethesda	/Bethe	esda-(Chevy 2001	Chase 4 – 3501	, Inc.
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that co	aused the death	h. Do not ent	er the mode of	dying, such a	as cardiac	or respiratory a	rrest,			Approximat Interval Bet	ween
Physician		Immediate Cause (Final disease or condition	a Pol	10									Onset and I Years	
/Medical _. Examiner		resulting in death)		or as a conseq	uence of):									
LAAIIIIIEI	L	Sequentially list conditions,		gestive		t Failu	re						Years	
ed isit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.0 600	or as a conseq	derice or):									
be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):							-		
sician buria			d											
ficate physical strine	Physician/Medical		. a.											
eath certific attending pl	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			75				23	ld. Date	of deliver	у	
death e atte od for	lcia	in the past 12 months? 1 □ Yes 2 ☒ No	4☐Pregn	irth 2 ☐ Feta ant at time of d]Ectopic pregn:] Other <i>(specif</i>)					Month	n 1	Day \	Year
of the	hys	9 □ Unknown	9□ Unkno	own					7					
The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	by F	Part II. Other significant conditions of	ontributing to de	eath but not res	ulting in the u	nderlying cause	e given in Pai	rt I.					e cause of c	
w require been sig should b									1 🗆 '	Yes 2□	No 3	☐ Proba	ibiy 4 K J	Unknown
law r las be	Completed								24a. Was autop	osy	pric	or to com	sy findings	available ause of
	Con								1 ☐ Yes	rmed? 2X No		ath?]Yes :	2□ No	
sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	<u> </u>			Other		h (Check only d			-		
Phys this ral dir	10	1 X Yes 2 No 27. Manner of Death	28a. Date (ER/Outpatier 28b. Time of		40		me 5X Residente 1 28d. Describe I)	_
ding h. After fune	tion	1 Natural 5 ☐ Pending	(Mont	h, Day Year)	Injury		Injury at Work? 1 Tyes 2		200. 2000	ion anjury	00001100			
Atten deat ctor: y the	fica	3 Suicide 6 Could not b	28e. Place	of tnjury - At ho	ome, farm, str				28f. Location (S		Number	or Aural	Route Num	iber.
alor/ after Dira	Certification;	4 Homicide	buildie	ng, etc. (Specif	y)				City or Tov	wn, State)				
To the Hospital or Attending Physician: within 24 hours after deals. To the Funaral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 N Certifying Ph (Check only one) 2 Medical Exam	ysician: To the niner: On the ba and mann	asis of examina	wledge, deat tion and/or in	h occurred at the vestigation, in r	ne time, date my opinion, d	and place, eath occur	and due to the red at the time,	cause(s) a date and p	nd mann lace, and	ner as sta d due to	ited. the cause(s	;}
To tha within 2 To tha complet	Me	29b. Signature and title of certifie	2			29c. Lic	cense numbe	ır		29d. Date	signed (Month, E	Day, Year)	
1) -/X()/	(al)	111			D35792			May	74,	200	5	
2-1		30. Name and address of pers in who	completed caus	of Jeath (Ite)	23a) (Type,	Print)								
		Swaroop Rao, M.D.	50 Wes	t Edmon	ston D	rive, #	504, Ro	ckvi	lle, Man	<u>rylan</u>	d 2	0852	-12 42	
Sta Registr		31. Date filed (Month, Day, Year)	0 6 200 5	egistra Signa	in the	Second 1	W.							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Marylan		artment of H rtificate of I			iene 0 0 5	15409
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		AILEEN	Ζ.		POULAKIS		MAY	3 200	
	Examin	er	4a. Facility Name (If not institution, give		_	1	Location of Death	,	4c. County of I	
				BALTIMORE 7. Age (In yrs.		BALTIM If Under 1 Year	ORE If Under 24 Hrs.	8. Date of Birth		N/A
	Funeral Director			M 2 F 77	Yrs.	Months Days	Hours Min.	APR. 11,	Ĭ928	Birthplace (State or Foreign Country)
		ŀ	Usual Residence of Decedent			J.,,	1	,		
	how		10a. State 10b. County	10c. City	y, Town or Lo	ecation				10d. Inside City Limits
	Ba-f s	cto	MD N/A		BALT	IMORE				1 V Yes 2 □ No
	vith th	Dire	10e. Street and Number			10f. Zip Code	01015	10	og. Citizen of Wha	USA
	sath v	erai	7103 BOXFORD ROA	U 12. Was Decedent Ever in U.	S 13 1	Was Decedent of H	21215 ispanic Origin? (Spe	acify Vas or No-	14 Bace -	American Indian,
35	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Itams 23e or 28e-f show appringnt or other traumatic event, the Medical Evantral terroillist at angre.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)		White, etc. WHITE
21215-0036	2 hou atura	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of Busin	ess/Industry
2	thin 7 a. en "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)			004
V	ed wi	Completed	12		MANI	CURIST			COSMETOL	UGY
	ba fill	Be	17. Father's Name (First, Middle, Last)		LIDM	ΔNI	18. Mother's Name	ə (First, Middlə, N	Maiden Sumame)	KIMMEL
3	should ind Men s marka umatic	2	MICHAEL 19a. Informant's Name/Relationship (Ty	nn Drint)	LIPM		LENA and Number or Rura	al Pouta Number	City or Tourn Sto	
Maryland	d 2 st th and 7 Is r traur		GEORGE N. POULAK				ROAD - I			
ย์	t and Health tem 27 other tr		20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of		-	20c. Location - Cit	
ē	Pagas nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		GE CEMETE		5/2005	PIKESV	ILLE, MD
aitimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens				ss of Facility SOI			
ñ	Depare Important in sany ir		Kolito 6	Lum						E, MD 21208
•			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the death	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician	4	Immediate Cause (Final disease or condition	CARDIO VA	SCULA	R DISER	SE			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq						
	Examiner	L	Sequentially list conditions,)	uaaaa afti					
	bed isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	derice or).					
_6	xecut and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8/60,	icate be executed physician and s the burial-transit	dicai E		1						
Q	tificat ig phy as thi	ledi								
O. Box	The law requires that the death certift ate has bach signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date o Month	f delivery Day Year
1	that the	/ Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
S D	uires sign ld be	d by						1 □ Ye	s 2 No 3	Probably 4. Unknown
Vital Records,	w requir baen si should	Completed						24a. Was a	n 24b. We	re autopsy findings available
9	The lav	шс						autops perform	ned? dea	r to completion of cause of th? Yes 2 No
<u> </u>	icien: Th	a)	25. Was case referred to medical				26. Place of Deat			165 22 10
<u>=</u>	Physicien: this certifica al director,	To B	examiner?	lospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	00		nce 6 Other	(Specify)
ס ר	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred	
<u></u>	endir sath. or: Al	atic	2 Accident investigation				Yes 2□No			
Division	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st fy)	reet, factory, office		28f. Location (St. City or Town		or Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.		202 Cartifier 12 Cartifular Dh.	sician: To the best of my kno	wedge de-	h occurred at the time	no date and place	and due to the an	use(s) and mann	er as stated
	24 hc Fun stely f	edical		ner: On the basis of examina and manner stated.						
	o the	Med	29b. Signature and title of certifier	200000000000000000000000000000000000000		29c. Licens			9d. Date signed (/	
	- s + ō		Sonnoa	0		DOC	2678	18 P	1AY 3,0	2005
	P		30. Name and address of person who o	DEPARTMENT	OF AN	Print)				BALTIMORE
	Sta	te	31. Date filed (Month, Day, Year)	. Registrar's Signa	ature	M.				
	Regist	ar	MAY 0 6 2005	Server Di	Aires	40				

			For Stete Registrar	State of Ma		/ Depa		of He	ealth a			jiene	Ü	154	10
	Physici		1. Decedent's Name (First, Middle, La PAUL V.	st) ROCKHILI							2. Date of Dea Month APRIL	th 28, 200	Year 5	3. Time of 9:45 I	
	/Medio Examin		4a. Fecility Name (If not institution, given FREDERICK MEMOR.		AL		4b. City, To			f Death		4c. County FREDE:	of Death	1-1-1-	
	Funeral Director		173-10-3882	Sex 7. Ago INM 2□ F	e (In yrs. ias 88	t birthday) Yrs.	If Under 1 \ Months D	ear ays	If Under 2 Hours	Min.	8. Date of Birth (Month, Day June 2	, Year) 7, 1916	9. Birth Cou	place (State or ntry) PA	r Foreign
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside Cit	
	the Ma 28a-f s	Director	PA 10e. Street and Number	Bucks			10f. Zip Co		rist	ol	1	log. Citizen of V	Vhat Cou	1 🗆 Yes	X
	s 23a or		7011 Riverview A			140					19007		JSA	can Indian,	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other treumetic event. The Nedical Examinational De rotified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		'	was Deceden f Yes, specify 1 ☐ Yes 2 ☑	Cuban	Specify:	in? (Spe , Puerto I	city Yes or No- Rican, etc.)		k, White,		
15-0	in 72 ho n "natur	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	ient's Usual C kind of work of DO NOT use r	done du	ion iring most	of workii	ng	16b. Kind of Bu	siness/ir	dustry	
212	e filed with al Hygiene. other than vent. the N		Elementary/Secondary (0-12)	College (1-4or 5	i+)		Owner		Opera		(Final Mindella	Maidan Cuman		y Prod	ucts
land	should be fill and Mental H marked otlumeric even	To Be	17. Father's Name (First, Middle, Last William Rockhill						18. Mothe		ce Lodg	Maiden Sumam Je	θ)		
Maryland 21215-0036	and 2 should I ealth and Meni n 27 Is marke ier treumetic		19a. Informant's Name/Relationship (Linda Michel / I								nghorne	r, City or Town, PA 1	State, Zij 9047		
iore,	iges 1 and 2 it of Health it item 27 i		20a. Method of Disposition 1 Burial 2 Cremation 3		cerr	netery, crer	sition (Name natory or othe	r place,			415	20c. Location -			PA
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		4 ☐ Donation 5 ☐ Other (Special 21. ☐ Other of European Carvice Lice			22	. Name and A	Address	of Facility	,	3, 2005 Euneral			Towns	птр
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused	the death.								1230	Approximate Interval Betw	reen
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as		MONIA								Onset and D	eath
	Examiner	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as									4		
	acuted tnd transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с											
68760,	ate be executed hysician and the burial-transit	icai	lossiting in death, East	Due to (or as	a conseque	nce or):		_							
.O. Box	death certific e attending p ad for use as l	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3□	Ectopic pregr Other (speca					23d. Date Mor			ear
<u>α</u>	sign sign d be	by	Part II. Other significant conditions (ONGESTIVE Hear	t Failure	ut not resulti	ing in the u	nderlying caus	se giver	n in Part I.			bacco use contr es 2 ☐ No	ibute to t 3 Prot	/	eath? nknown
al Records,	The ite h	Completed	Renal Failure	S							24a. Was a autops perform	med? d	Vere autorior to co eath?	opsy findings a impletion of ca 2 No	vailable use of
Vital	Physiclan: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 EF	VOutpatien	t 3 DOA	Other			(Check only on ne 5 ☐ Reside	ence 6 □Othe	er (Specia	(v)	
on of	ding h. After fune		27. Manner of Death 1. Natural 5 Pending investigation	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury	28c.	Injury a		2		ow injury occurre			
Division	or Atten iter dea Sirector in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	Ope Place of Inju	ury - At home c. (Specify)	e, farm, str					8f. Location (Si City or Town	reet and Numbe n, State)	or Aura	al Route Numb	per,
	Hospita 4 hours Funeral	Medical C		nysician: To the best on miner: On the basis of and manner sta	examination										
	To the within 2 To the complet	Me	29b. Signature and title of certifier	.D.					number	793		9d. Date signed	(Month. 8/0.		
7	25		30. Name and address of person who		eath (Item 2	3a) (Type						1/2			
	Sta Registr		31. Date filed (Month, Day, Year)	32. egistra	ar's Signatur		anth's								

		-	For State Registrar	State of Maryla	nd / Depa	artment of H	lealth and i	Mental Hyg	iene og. No 2005	15411
	Physici /Medio	al	1. Decedent's Name (First, Midd CLRISTOPHEK 4a. Facility Name (If not institution	C G RYAN on, give street and number)	565	4b. City, Town, or		2. Date of Death Month MAY		3. Time of Death 7:17A. M
	Funeral Director		SOUTH BOUND I Source Social Security Number 152-6-4954 Usual Residence of Decedent	95 @ Mile Marker 6. Sex 18 M 2 F 7. Age (In yr	565 s. last birthday) Yrs.	BALTI If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3-29	Year) 9. Birth	nplace (State or Foreign untry)
	ne Maryland 8e-f show outfied at	Director	10a. State 10b. Count MON	2 .	City, Town or Lo	ドナ				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	hours after death with the Maryland lural; or Items 23a or 28e-f show al Examinar must be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Ma	If Yes, Give		Was Decedent of Hilf Yes, specify Cuba	738 ispanic Origin? (S In, Mexican, Puerl Specify:		Og. Citizen of What Co	orican Indian,
21215-0036	within 72 hou ene. than "netura be Medical E	Completed by	3 Widowed 4 Divorce 15. Decede (Specify only higher Elementary/Secondary (0-12)	int's Education est grade completed)	16a. Dece (Give lite.	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	rking	Account	
Maryland 2	should be filed and Mental Hygi marked other matic event, it	To Be C	17. Father's Name (First, Middle	YAN			ARLEN	ne (First, Middle, M VE ARK)	Maiden Sumame) NS	
	1 and 2 s Health ar Her 1 s		19a. Informant's Name/Relation MELISSA RYAN 20a. Method of Disposition	N. WIFE	SOI N	Sition (Name of	kings Ro	LINCROF	City or Town, State, 2	33
Baltimore,	it. Pages rtment of rtant: If It njury or o		1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (MATCOM	matory or other place Model Page Name and Address	ss of Facility		INTON FAILS,	N.J.
a a	Depa Depa Impo any i		23a. Part 1. Enter the disease, o shock, or heart failure. Lis	or complications that caused the dest only one cause on each line.	eath. Do not ent	2601	Mountain Road	- Pasadena, M	ation Center, P.A. D. 21122	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Multi		njuries				Onset and Death
	te be executed ysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a const						
	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fc 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	very Day Year
rds, P.O	v requires that t been signed by should be deta	ρ	Part II. Other significant condit	tions contributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
of Vital Records,		Completed						24a. Was an autops perform 1 Yes 2	y prior to	topsy findings available completion of cause of 2 No
Vita	sician: Th certificate irector, pag	o Be	25. Was case referred to medic examiner? 1 □XYes 2 □ No	Hospital:	☐ ER/Outpatier	other actions of the		ath (Check only on	e) ince 6X1Other <i>(Spe</i>	ACCENIE
Division of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, sompletely filled in by the funeral director.	Certification: To	27. Manner of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Could	ling (Month, Day Year)	28b. Time of Injury	f 28c. Injun World M 1 Treet, factory, office	y at k?	28d. Describe ho	w injury occurred motor vehicle mothe	e that collided moter which will all moters with the war some sumber. Sound I 95 @
	he Hospital or n 24 hours afte he Funeral Dir pletely filled in	Medical C		ing Physician: To the best of my kal Examiner: On the basis of examinand manner stated.	nowledge, deat	h occurred at the tin		and due to the ca	iuse(s) and manner as	stated.
	To the within To the comp	Σ	29b. Signature and title of certifi	ier mid		29c. Licenso			9d. Date signed (Mont	
				n who completed cause of death (II	em 23a) (Type,	Print)	CME		IAY 2, 2005	
			L (/) G 31. Date filed (Month, Day, Yea	LI, MD 32. Registrar's Sig	nature			Baltimo	ore, Maryla	and 21201
	Sta Regist			MAY 0 6 2005	Patrim to	n Sperk	2			

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 2. Date of Death Month May 4, 2005 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Year Elizabeth Jean Ruley 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 111 North Stuart Street Essex Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
April 17,1931 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Months Hours 1 □ M 2 🖫 F Director 74 Yrs. 212-28-4006 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23e or 28a-f show 1 Yes 2 XX Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 North Stuart Street 21221 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify 3X Widowed 4 ☐ Divorced White "naturel" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Accounting 12 . Pages 1 and 2 should be filed w thent of Health and Mental Hygie tent: if item 27 is marked other to jury or other treumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carl William Orr Blanche Bolen Shaqena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 North Stuart Street, Essex, Maryland 21221 Thomas Ruley (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. 05/06/2005 Baltimore, Maryland ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Sonator of Funeral Service Life 236. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 Weeks Metastatic Non-Small Cell Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of); physicien Physiclan/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, been signe should be d 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 1 ☐ Yes 2**5**0No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2XXVI0 Certification; To 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō the Hospitel *Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16861 MA4 06, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2200 Baltimore MD 21237

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32 Registrans Signature

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	•	For State Registrar		Otato	or ivial ylar	nd / Dep Ce	rtificat					g. No.	00	5	15413
, Physicia	ın.	1. Decedent's Name (First, Darlene E			1100					M	ate of Death onth	Day	2008	ar	3. Time of Death
/Medica	al .	4a. Fecility Name (If not in:					4h City	Town or I	ocation of Dea	Ma	У	-	County of D		2:30 p M
Examine	er	Gilchrist (-		ambory			wson	LOCATION OF DEC				Ba	ltim	ore
Funeral Director		5. Social Security Number 215–50–2920	6. Se	ox □ M Ž Ö (F	7. Age (In yrs. 57	last birthday Yrs.	Months	Days	If Under 24 Hr Hours Min	n. Oct	ate of Birth lonth, Play,	Year)	9. 7 M	Birthplac Country ALY L	e (State or Foreigr and
p		Usual Residence of Deced	ent		10c. Ci	ity, Town or L	ocation					_		10d.	Inside City Limits
Maryli 1 sho	ţō	Maryland Ba	altimo	re		Reist		wn							1 ☐ Yes 2 ☐ No
th the or 28a	lrec	10e. Street and Number					10f. Zij	Code			10	Og. Citiz	en of What	Country	?
ath wi	la L	202 Cork 1	Lane #					2113					S.A.		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. It is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, the Modical Exercitivat, and by notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2[3 Widowed 4 1006		Armed F	2 🐴 No live	J.S. 13.	Was Dece If Yes, spe	20.00	panic Origin? (, Mexican, Pue Specify:	(Specify Y erto Rican	es or No- , etc.)		4. Race - A Black, W Specify:	merican /hite, etc Whi	
2-UC	sted	15. De	cedent's Ed	ucation de completed	"	16a. Deci	edent's Usu	al Occupat	ion uring most of w	vorkina	1	l 6b. Kir	nd of Busine	ss/Indus	try
within noe.	Completed	Elementary/Secondary ((1-4or 5+)	1	<i>bo Not</i> i		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				yland	Carn	
filed v Hygie Sthar I ant, III	a	17. Father's Name (First, M	Aiddle, Last)				aorec i		18. Mother's N	ame (First				Oup	
rkad c	ToB	Donzal Me	eredit	h Love	ll Sr.				Doris	Elai	ne St	ott:	lemye:	r	
2 sho and N is ma		19a. Informant's Name/Re	, ,				-		nd Number or F			-			
1 and Health Am 27 Thar tr		Doris Lovel		ther	20b.	1235. Place of Disp			ing Ave	Date			Ls, Mo		
nt of It. If its		1 Burial 2 ☐ Cren 14 ☐ Donation 5 ☐ O	nation 3 🗌		State	cemetery, cre seburg	matory or	other place	9,2005				tehall		
ourtme contan		21. Signature of Funeral S	ervice Licen	S00	1				of Facility				CCIIQI.	E 9 27.10	A .
Depart Impo		23a. Part 1. Enter the dise shock, or heart failur				17	1605	neist	erstown	1 Rd.	Owin	80 l	ills.	, Md.	21117
Physician // Medical Examiner study fundal-transit study purial-transit study fundal-transit study funda-transit study fu	sal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ξ, θ	b. Due to	o (or as a consector)	Leguence of):	Pr	veum	mih						nset and Death
y the attending phy. Iched tor use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 □ Yes 2 M No 9 □ Unknown	ant	1 Live	utcome of pregn birth 2 Fet gnant at time of on nown	al death 3	□Éctopic p □ Other (s)					2	3d. Date of Month	delivery Da	y Year
	by Ph	Part II. Other significant of	onditions co	ontributing to	death but not re	sulting in the	underlying (cause giver	n in Part I.	2				1	ause of death?
v requir been si should										-	1 ☐ Ye	s 2L	No 31	Probabl	y 4 □Unknown
After this certificate has b funeral director, page 2 st	Completed									-	4a. Wes ar autopsy perform ☐ Yes 2	/	24b. Were prior death	to compl 1?	findings available etion of cause of
Physician: r this certitic ral director,	Be c	25. Was case referred to examiner?	1	Hospital:	Inpatient 2] ER/Outpatie		Other	26. Place of D				W h		0040(
g Phy er this eral d	n: To	27. Manner of Death		28a. Date	of Injury nth, Day Year)	28b. Time		28c. Injury Work	4 Nursing		escribe ho		Occurred	респу) 🗸	wspice
To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident	Pending investigation Could not be determined	28e. Plac	ce of Injury - At h	nome, farm, s	М	1 🗆 Y	es 2□No		ocation (Strity or Town		l Number or	Rural Ro	oute Number,
Mospital 24 hours Funaral etely filled	Medical C			niner: On the	ne best of my kn basis of examin nner stated.										
To the within To the	Me	29b. Signature and tiple of	certifier	0			29	c. License					signed (M		
		· All	la	Un	~>			D5	830	3	V	MA	45	200	2
			7.5											1231153	
5		30. Name and address of	person who	completed cau	use of death (Ite (es inv)	m 23a) (Type	, Print)	Cha	rles 1	r B	altr	uda	e Lui	171	20.

CPM 05-02976 Charles Roberts

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] 5 54 4 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Roberts Jr. April **Physician** 2005 Alfred 21:12 Charles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1657 North Milton Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Yrs. 213-66-9524 Director MD 49 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21213 1657 North Milton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 ö 1 Yes No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Distribution Clerk U.S. Postal Service 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be marked Bessie Viola Bryant Charles Alfred Roberts Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau once. 21215 2921 Thorndale Ave, Baltimore, Md Justian J. Roberts-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Arbutus Memorial Park 5/10/05 Arbutus, Md 21. Signature of Funeral Service Licenses March F/H West Wieere Edmon 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final terios **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, , page 2 should be No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of cath?

Yes 2□ No 24a. Was an has autopsy performed 2 No Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1X Yes Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Other (Specify) SCENE 2 🗌 No this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t Natura. 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 50 Hospital e Funeral I 29a. Certifier 🗆 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely within 2 and manner stated 29d. Date signed (Month, Day, Year) dure and title of certifies 29c. License number O.C.M.E. April 30, 2005 who completed cause of death (Item 23a) (Type Print)

111 Penn Street, Baltimore, Maryland 21201 ROM My 31. Date filed (Month, Day, Year) 32. Registres Signature State MAY 0 6 2005 Registrar

		For State Registrar	State of N	Maryland /		irtment of H		nd Mental Hy	giene Reg. No	105	
		Decedent's Name (First, Middle,	Last)					2. Date of De	ath	المياليا.	3. Time of Death
Physic		HENRIETTA	WEBSTER S	NOWDEN				Month APril	29th	2005	4.00 AM
/Medio		4a. Facility Name (If not institution,				4b. City, Town, or	Location of		-	nty of Death	
LAGIIII	iei	UNION MEMORIAL	HOSPTTAT.			BALTIM	ORE			N/A	
Funeral			S. Sex 7. A	Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bit Min. (Month, Da	th v Year)	1	lace (State or Foreign
Director		212-30-2657	1 □ M 2XXF	73	Yrs.	WOTHIS Days	Hours	JUNE 1	7 1931		RYLAND
p ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	our or Lo	nation				1	0d. Inside City Limits
aryle shov	2			Too. Oity, 11							1 □ Yes 2XXNo
he M	Director	MARYLAND HARFO	RD CO		DI	ARLINGTON 10f. Zip Code	-		10g. Citizen	of Mhat Cour	stn/2
with t		10e. Street and Number									y.
s 23	eral	1213 HOLLOWAY	ROAD 12. Was Deceder	t Ever in U.S.	13 \	Vas Decedent of Hi		in? (Specify Yes or No	U.S.	A.	an Indian
Iten d	Funeral	1 Never Married 2 Marrie	Armed Forces	5?			n, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	1	lack, White,	etc.
036 urs at	Ď	XXWidowed 4 □ Divorced	If Yes, Give Year or Dates	=		☐ Yes XX No	Specify:		Spe	cify: BLAC	CK
1215-0036 within 72 hours after death with the Marylend ene. ene. than "naturat", or Items 23s or 28e-f show na Modical Examinar must be inclined at	Completed	15. Decedent's		1	6a. Deced	lent's Usual Occupa kind of work done of	ation	of working	16b. Kind of	Business/Inc	dustry
212 thin 7	adr.	Elementary/Secondary (0-12)	College (1-40	r 5+)	life. L	OO NOT use retired)	or working	BOARD	OF EDU	JCATION
d 21 filed wil Hygien stherth	Con	12th grade			CUST	DDIAN				ORD CO	·
laryland 21215-0036 2 should be filed within 72 hours after death with the Marylen and Mental Hygiene. Is marked other than "natural; or Items 23a or 28e-f show emmatic event, the Madical Examiner must be nutified at	Be	17. Father's Name (First, Middle, La	ast)				18. Mother	's Name (First, Middle	, Maiden Sum	ame)	
arylan should be nd Mental s marked o	မ	STANTON WEBSTER						INA WEBSTE			
Maryland 21215-0036 d 2 should be liled within 72 hours all th and Mental Hygiene. ?? Is marked other than "natural", or treumatic event, the Medical Exten		19a. Informant's Name/Relationshi	p (Type, Print)					or Rural Route Numb			
C = 64 F		Denise Snowden/ 20a. Method of Disposition	Daughter			Holloway	Rd.,	Darlington		21034 n - City or To	
more, Pages 1 ar		1 XXurial 2 ☐ Cremation		e ceme	etery, cren	natory or other place	· 1				
timer ritmer ritent		' 4 ☐ Donation 5 ☐ Other (Special September 21. Signature of Coneral September 21.		BERK		EMETERY Name and Addres		5-03-05	DARLIN	IGTON,	MARYLAND
Baltimor permit. Pages Depertment of t Importent: If its any injury or of once.		21. Signature of different Service to	censee		WI	1 C BROWN	COMM	JNITY FUNE			
	- 10	Sa. Part1. Enter the disease, or c	omplications that caus	ed the death. [1					IN MAR	(LAND 21001 Approximate
4	1	shock, or heart failure. List o Immediate Cause (Final	nly one cause on each	line.		,					Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	as a consequen	on of):					_	2 days
Examiner			A cul	(7)	nal	tailur	0				2 days
E MAD	ē	Sequentially list conditions, if any, leading to immediate	0.	is a consequen		0 00 000					
d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Ser	515							7 days
O, en en rial-tr	Exa	resulting in death) Last	Due to (or a	as a consequen	,	0 0 1 11 1		T.	- 1		El Late
18760, Cate be executed physicien end it the burial-transit	dlcal	10	a poly	myosit	7'5 (Methot	redute	Toxicit			2 wks
rtifica ing ph		IF FEMALE:									
Box 6	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	ath 3□	Ectopic pregnancy			1	Date of delive Month	ory Day Year
the deay y the a	/sic	1 ☐ Yes 2 D No 9 ☐ Unknown	4∐Pregnant 9□ Unknown	at time of death	າ 5∟	Other (specify)					
d bat d	by Physician/Me	Part II. Other significant condition	s contributing to death	but not resultin	g in the ur	nderlying cause give	en in Part I.	23e. Did 1	obacco use co	ontribute to th	e cause of death?
Vital Records, sicien: The law requires the certificate has been signe rector, page 2 should be contracted.	db		J		Ų.			1 🗆	Yes 2. ☑No	3 🗆 Prob	ably 4 Unknown
Cord	Completed							24a. Was	an 24	. Were auto	psy findings available
Vital Rec sicien: The law certificete has t irector, page 2 s	du							auto perfo	psy ormed?	prior to cor death?	npletion of cause of
n: Ti		25. Was case referred to medical					OF Place	of Death (Check only	2 No	1 🗆 Yes	210 No
of Vital Re Physicien: The Is this certificate ha: ral director, page 2	To Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 X Inpa	tient 2 TER/	/Outpatien	t 3 DOA Othe	ar.	sing Home 5 ☐ Resi		ther (Specifi	()
Vision of Vital Attending Physicien: r death. setor: After this certified by the funeral director, I		27. Manner of Death	28a. Date of in	ijury 28	b. Time of		at at	28d. Describe			,
inding ath. r: Aft	atio	t X Natural 5 ☐ Pending 2 ☐ Accident investiga		Jay (Gai)	Injury		Yes 2□N	ło			
Division of to attending Physater death. Director: Atter this in by the funeral di	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of I	njury - At home etc. (Specify)	, farm, str	eet, factory, office		28f. Location (City or To	Street and Nu	mber or Rura	l Route Number,
Div tel or A rs after el Dirac	Certification:										
Hospi 4 hou Tuner	cal		Physician: To the bes xaminer: On the basis								
Div To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	Medical	one)	and manner			29c. License			29d. Date sig		
To Too		29b. Signature and title of certifier Bangaria R	amal C.	M.D.		ļ.	438	a Lt-C	A phil		2005
							100	7-10	1 Previ		
a		30. Name and address of person w					eraitu	PKWY [Baltim	ano	MD-21218
Sta	ate	31. Date filed (Month, Day, Year)	32_Begis	strar's Signature			19	11009	JULINITY	w ot	.0 9,018
Regist		MAY 0 6	2005	m K	A.	well .					

			For State Registrar	State of Man		artment of l		Mental Hy	/giene	05	15416
ī	Dhusisi		1. Decedent's Name (First, Middle,					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		JOHN SMI			4h City Tourn	or Location of De	APRIL		oc 5 y of Death	3 cop M
	Examin	er	4a. Facility Name (If not institution, g Mariner Healt		Catonsy		catonsv		1	alti	more
	Funeral		5. Social Security Number 6	. Sex 7. Age (In yrs. last birthday		If Under 24 H	rs. 8. Date of B	irth		place (State or Foreign
	Director		225-24-6063	X □M 2□F 8	Yrs.	Widnin's Days	TIOUIS IVII		2,1925		
	land bw		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation.				1	0d. Inside City Limits
	r 28a-f show	tor	Maryland N/A		Baltin	nore					1X Yes 2 □ No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
	s 23a or	rai	3831 Roland N			21 21		(Specify Ves or N	L	USA	ean Indian
^	fter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces? 1 Yes 27 No	31 11 0.3.	. Was Decedent of If Yes, specify Cub		erto Rican, etc.)	BI	ack, White,	etc.
5	tiled within 72 hours after death with the Maryland Hygiene. ther than "natural", or Hems 23a or 28a-f show ant, I've Medical Evanta art must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 🛂 No				⊮:Bla	
21215-0036	n 72 hours "natural", edicul Exe	Completed	15. Decedent's (Specify only highest	grade completed)	(Giv	edent's Usual Occu e kind of work done DO NDT use retire	during most of w		16b. Kind of		•
717	l withii jiene. r than	omp	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)		cionary	Engine	de #1 r	Cente		ve Hospit
חם	al Hyg	Bec	17. Father's Name (First, Middle, La					ame (First, Middl	e, Maiden Suma	me)	
Maryland	should be tind Mental I	ဥ	John Edward S		10b Mai	ling Address (Stree		e Keys	her City or Tow	State Zin	(Code)
Z	7 1.2 tra		Dorothy A. Sr								
re,	- 7 8 2		20a. Method of Disposition		20b. Place of Disp cemetery, cri	position (Name of ematory or other pla	ace) 5	Date / 6 / 0 5	20c. Location		
altimore,	Pages ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	cify)	Druid F	ematory or other place Ce	metery	70703			, Marylan
Ball	permit. Pages Department of I Important: If ite any injury or o'		21. Signature of Funeral Service Li	Alve	5	22. Name and Addr 5240 Rei	ess of Facility C	hatman- own Rd	Harris Baltim	Fun ore,	eralHome Md 21215
	1		23a. Part 1. Enter the disease, or co shock, or heart failure. List of	omplications that caused that you cause on each line.				iac or respiratory	arrest,		Approximate Interval Batween Onset and Death
	Priysician /Medical	í	Immediate Cause (Final disease or condition resulting in death)	a. ACUTE	RESPIRA	TORY F	AILURE				
	Examiner			TNEUM	consequence of):						
-	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Die to (or se s o	ronsequence of):						
V	ecuted and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):						
760,	The law requires that the death cartificate be executed tens been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	icai E		d	, , , , , , , , , , , , , , , , , , , ,						
89	tificate ng phys as the			<u> </u>							
Box	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	□Ectopic pregnan	су			ate of deliver	ery Day Year
o.	at the dea by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at tin 9 Unknown	ne or death 5	Other (specify)					
т, П	res that signed by be deta	by Pr	Part II. Other significant condition			underlying cause g	iven in Part I.				he cause of death?
Ž	w require been sig should b		ISCHEMIC C	ARDIOMYOPAT	7144 .			- 1	Yes 2 No	3 Prob	pably 4 Aunknown
Records,	e law r has be	Completed						24a. Wa aut	s an 24b opsy formed?		ppsy findings available mpletion of cause of
			DE Mas area referred to modical				OF Place of F	1 ☐ Yes Death (Check only	2 🗷 No	1 🗆 Yes	2 No
Vita	hysician: The law his certificate has I I director, page 2 s	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpati	ent 3 DOA		Home 5 Re		ther (Specif	(y)
Division of	ding Phys Ih. : After this funeral di		27. Mapner of Death	28a. Date of Injury (Month, Day)	(ear) 28b. Time	W		28d. Describe	how injury occu	ırred	
Sio	ttendir death. ctor: Ai y the fu	catio	2 Accident investiga 3 Suicide 6 Could no	t bo	At home form		☐ Yes 2 ☐ No	28f Location	(Street and Nun	nber or Rum	al Route Number,
<u> </u>	l or At after o Direc i in by	Certification:	4 Homicide determin	ed 28e. Place of Injury building, etc.	(Specify)	street, factory, office	,		own, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of kaminer: On the basis of e	my knowledge, dei	ath occurred at the	time, date and pla	ace, and due to th	e cause(s) and r	nanner as s	itated.
	the H hin 24 the F mplete	Medicai	one)	and manner state			nse number		29d. Date sign		
	5 1 × 0 8		29b. Signature and title of certifier	THYSICIAN			+2123	•	APRIL .	30	2005
)	17			ho completed cause of dea	th (Item 23a) (Type	e, Print) 5310	OLD	COURT	ROAD	SUIT	£ 303
	10		AVVERAHALLI	ITARISH 32 Begistr	s Signature	Should	VOALLIT	D W N	E GLW	1133 :	
	Sta Registi		31. Date filed (Month, Day, Year)	0 6 2005	MAN A	e, Print) 5315					

Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Mai	ryland / Depa	artment of H			/ 111	15	15417
			Registrar 1. Decedent's Name (First, Middle, La.	st)	- Cei	tineate of t	Jean	2. Date of Dea	Reg. No.		3. Time of Death
н	Physicia	an	CUIFTON J	SOTT	-			APRIL	Day 2	Year	O 6: 23 AM
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	FILE	4c. County		
	Examin	Ġ1	MERCY MEDIC	AL CENT	ER	BALTIM	ORE, MA	RYLAND	Buly	Morc	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v, Ye <i>ar</i>)	9. Birthplac	ce (State or Foreign
	Director		40-14-5209	M 2 F	U L Yrs.			01 1		M	
	and **	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d	I. Inside City Limits
	f sho	ō	MD Brot	mine	Bully	nov					1 No 2 No
	the 28a-	rect	10e. Street and Number	0 - 0		10f. Zip Code			10g. Citizen of W	/hat Country	/?
	n with	O ie	2300 leistusto	m foad		2121:	5		U.S	S.A.	
	72 hours after death with the Maryland naturel; or items 23a or 28a-f show Jical Evania et must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race Blac	- American k, White, etc	
92	or ite	y Fu	1 Never Married 2 Married	1 ☑ Yes 2 ☐ No		1 Yes 2 No	Specify:		Specify	RIGO	K-
8	hours urel',	d by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occup	ation		16b. Kind of Bu	siness/Indu	stry
21215-0036	n 72 nat	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	TOD. KING OF DO	31103311100	y
112	filed within Hygiene. ther then ont, it is New	mo	12th grade	College (1-4or 5+		elf Emp	loyed		Waste	Disp	osal Co.
ğ	0 0 0	BeC	17. Father's Name (First, Middle, Last				18. Mother's Nam	e (First, Middle,	Maiden Sumam	e)	
/lar	should be I ind Mental I imarked o umatic eve	ToE	Albert Scott	_			Lula Jo	ohnson			
Maryland	and and sum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street					
	1 and 2 Health tem 27 i	0	Clifton R. Sco	tt-Son	3828 20b. Place of Dispo	Ravenw		, Balt.	imore, 20c. Location -		21213
Baltimore,	0 0 = =		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other place	ce)				
ţ			'4 ☐ Donation 5 ☐ Other (Species 121. ig ature if Fu eral Service I ice		The second secon	n Fores		5/6/05	Owings	s M11	Is, Md
Bal	permit. Departr fmporte any nju		21. Ligrature il Funeral Secure il Ce		() M	larch F/	H West	D = 1 4	4	M A	21215
			23a. Part1. Enter the disease, or con	prijections that caused to	the death. Do not en	300 Wab ter the mode of dyir	asn ave ng, such as cardiac	or respiratory a	rrest,	F	Approximate nterval Between
	Service.		Immediate Cause (Final	one cause on each line	θ.					ä	Onset and Death
	/Medical		disease or condition resulting in death)	a. BRONCE Due to (or as a	consequence of):					_	
	Examiner		Conventially list conditions	b. PROST	ATE CAN	YCER					
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury	Due to (or as a	consequence of):						
V	and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or an a	consequence of):						
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit			506 10 (0) 23 2	consequence or,						
87	physi physi s the l	Physician/Medical		d							
Box 6	leath certifica attending ph I for use as th	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				23d. Dat	e of delivery	,
B	res that the death certigned by the attendin be detached for use	icial	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		□Ectopic pregnancy □ Other <i>(specify)</i> _	/ 		Moi	nth D	ay Year
O.	by the	hys	9 Unknown	9□ Unknown							
S, P	gned oe de	by P	Part II. Other significant conditions	contributing to death bu	it not resulting in the i	underlying cause giv	ren in Part I.		obacco use conti		
ord	w require been sig							1 🗆 '	Yes 22No	3 Probat	bly 4 □Unknown
Records,	e law r has be je 2 sh	Completed						24a. Was auto	osv l	prior to comp	sy findings available pletion of cause of
<u></u>	Th ate pag	Con						1 ✓ Yes		death?	M No
Vital	Phyelcien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ot 30 DOA Ott	26. Place of Dea				
of	Phyel this c	J.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 pullipatier		all SON	+ _ 11d.5ilig 11		dence 6 Oth	- ' ' ''	
n (ling After fune	ion	1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) Injury	Wo	rk? Yes 2 □ No		,,		
Division	Attending r death. ector: After by the fune	fical	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Inju	ury - At home, farm, s	treet, factory, office			Street and Numb	er or Rural I	Route Number,
Div	after after Dire	Certification:	4 Homicide	building, etc	c. (Specify)			City or To	wn, State)		
	Hospitai 24 hours 2 Funeret rely filled	aic	29a. Certifier 1 Certifying P	hysician: To the best of	of my knowledge, dea	th occurred at the ti	me, date and place	, and due to the	cause(s) and ma	nner as stat	ted.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and/or il			nou at the thie,			
	To the within 2 To the comple	Σ	29b. Signature and title of certifier)		29c. Licens			29d. Date signed	a (Month, Di	ay, rear)
			1 46010	МФ			5113		APRIL	27, 2	005
	141		30. Name and address of person who				4		/ ten		
	<u> </u>		GRISHMA JOS 31. Date filed (Month, Day, Year)	32. Pagistra	MIVERS ITY ar's Signature	OF MAK	CLAND MI	EDICAL	CONIEK		
1903	St: Regist	ate rar	MAY 0 6	2005	ar's Signature	porte					
				1			-				

		-	For State Registrar	State of	Maryland		artment tificate			and M	lental Hy	giene Reg. No.	005	15418
	Physicia	200	1. Decedent's Name (First, Middle, Las	,							2. Date of De Month	aath Day	Year	3. Time of Death
	/Medic		LAURENCE G. S				45 02 3		1	10	APRIL		2005 County of Dea	11:15 A ^M
ł.	Examin	er	 Facility Name (If not institution, give 839 Woodmont Rd. 	street and num	ber)			apol	Location o	of Death			Anne A	
36	Funeral	7	5. Social Security Number 6. S	ex 7	'. Age (In yrs. las	st birthday)	If Under	1 Year	If Under		8. Date of Bi			rthplace (State or Foreign Country)
D	Director		215-28-4149	M M 2□ F	73	Yrs.	Months	Days	Hours	Min.	1-1-1	932		w York
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c, City.	Town or Lo	cation							10d. Inside City Limits
	Maryle 1 sho	5												1 ☐ Yes 2 XNo
	the r	Funeral Director	Maryland Anne Aru 10e. Street and Number	naei		Annar	10f. Zip	Code				10g. Citi:	zen of What C	Country?
	th with	al D	839 Woodmont Rd.					214	101				USA	
	ems a	iner	11. Marital Status	Armod For	dent Ever in U.S. ces?	13.	Vas Deced f Yes, spec	ent of His	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh	
36	s afte	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes	2 □ No tes:1953-5	7	1 ☐ Yes 2	No Mg	Specify:				Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "neturel", or items 23s or 28e-f show event, it a Madical Extrait ett and be notified a		15. Decedent's Ed		(63. 1903-0	16a. Dece	dent's Usua	I Occupa	ition			16b. Ki	nd of Business	s/Industry
215	within 72 iene. than "ne the Medi	plet	(Specify only highest gra	de completed) College (1-	4or 5+)	(Give lite. i	kind of wor DO NOT us	k done d e retired)	lu <i>ring m</i> os)	t of work	ing			
21	filed wit Hygiene Nher th	Completed		4 years		Budget	& Fi	nanc					. Gove	rnment
and	be filed htal Hygie ed other event, II	Be	17. Father's Name (First, Middle, Last) Laurence		towart						e (First, Middle ller	, Maiden	Sumame)	
Maryland	2 should be and Mental le marked raumatic ev	ဥ	19a. Informant's Name/Relationship (Lewart	19b. Mailir	ng Address	(Street a			al Route Numb	er, City o	r Town, State,	Zip Code)
Z	교육21		Rosemarie H. Stew		fe		-				apolis,			
e,	es 1 ar of Hea of Item 3		20a. Method of Disposition	D	cen	ce of Dispo	sition (Nam	ne of ther place	9)		Date	20c. Lo	cation - City o	r Town, State
altimore,	Pages nent of ent: If it ury or o		1 ☐ Burial 2 💢 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		Kal	as Cr				5-6-			ewater	
Balt	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licer	la										RAL HOME R, MD.21037
U			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	used the death. ch line.	1		e of dying	g, such as	cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Met	astallic		ind	cal	Neen				11000	Z WD
	/Medical Examiner		Due to (or as a consequence or):										MAKRONN	
	t e	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								OLA HEATONO A			
a,	cate be executed obysician and the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.											
0,	be executed ician and burial-transit		resulting in death) Last	Due to (d	or as a conseque	ence of):								
8760,	cate b physic the b	Physician/Medical	•	d										
9 X	death certific e attending p id for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnan							2	23d. Date of de	elivery
Box	death e atter d for u	Iclar	in the past 12 months?	4□Pregna	rth 2 ☐ Fetal o ant at time of dea]Ectopic pro] Other <i>(sp</i> o						Month	Day Year
P.0		hys	9 Unknown	9□Unkno	WIT							- 1	- 29	A
Vital Records, F	Se Log	by	Part II. Other significant conditions of	contributing to de	ath but not result	ting in the u	nderlying ca	ause give	en in Part I			tobacco u Yes 2[to the cause of death? Probably 4 Unknown
900	aw Is b	Completed									24a. Was		24b. Were a	autopsy findings available completion of cause of
I B	Th ate pag	Com										ormed? 2 No	death?	es 2 No
/ita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:				A Othe	25		h (Check only			
of	Physe this ral di	- To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date o		R/Outpatier 28b. Time o		8c. Injury	4 🗀 140	irsing Ho	me 5 v es 28d. Describe		6 □Other (Sp y occurred	ecity)
	Attending F r death. ector: After by the funer	tlon	yatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month	n, Day Year)	Injury	М	Work	<br Yes 2□	No				
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place buildin	of Injury - At hom g, etc. (Specify)	ne, farm, sti	reet, factory	, office				(Street an wn, State		Rural Route Number,
	urs urs aref		29a. Certifier Certifying Pt	veician: To the	hest of my know	ledne deat	h occurred	at the tim	ne date ar	d place	and due to the	Canso(s)	and manner	as stated
	To the Hospital or Att within 24 hours after de To the Funerel Direct completely filled in by t	edical	(Check only 2 Medical Example)		sis of examination									
	To the within 2 To the complet	Me	29b. Signatule and title of certifier		101	In	290	. License	number	0 1		29d. Dat	e signed (Mor	nth, Day, Year)
	On		• WILLIE	COOK	NU N	(V)	Peigr)) (123	21		Fla	7 3/	1005
	.7.		30. Name and address of person who	1 1 0	5100	23a) (Type,	echor	vols	W	Ro	1.1200	KUI	le MI)20852
Ŀ	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 6 2	005 32. Re	egistrar's Signatu	S So	ule)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Mc Kathleen 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number Medical Center 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 216-52-107 Hours 1 M 200 F Months Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other then "neturel", or items 23e or 28a-f show treumatic event, the Medical Evant are must be codified at 1 Yes 2 No Director BaltIMORE undalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code U.S.A 3 tanhobe 1923 21222 Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married □Yes 2 100 1 ☐ Yes 2 No Maryland 21215-0036 Specify. Specify: Whi 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then College (1-4or 5+) MEDICAL Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and Mental H Bettendor HRIENE 19a. Informant's Name/ elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter E. Stahl Stanhore 21222 1923 Rd. DUNDAIK MD Department of Health Importent: If item 27 other t 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State injury or LOUDON Park CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility.

Bradley-Ashton Funcral Home, P.A.
2.134 Willow Spring Rd. 21. Signature of Funeral Service Licens any in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athenisclenti artem connary Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a Examiner physician and the burial-transit The taw requires that the death certificate be executed Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9☐ Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed 2 X No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No Certification; To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospitel or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 - Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.

Theodore 31. Date filed (Month, Day, Year) Stephens, 1005 32. Registrar's Signature

0-41399

North Point Blud, Ste 724, Bultimore, ND 2124

03

Garnett A. Vinson 05-

AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

303	35		1 - For State Registrar		State of M	aryland / [Depa <i>Cei</i>	artment of I	Health and M Death	Mental H	ygiene	05	1542
	Physic /Medi		Decedent's Nam GARNET'	ne (First, Middle, La T A.	VINSON	JR.				2. Date of D May 2	eath	Year	3. Time of Death 2:50 A M
	Exami			opkins Ho	street and number)			4b. City, Town, o Baltimo	or Location of Death			nty of Death	
	Funeral Director		5. Social Security	-7171	ex 7. Ag	ge (In yrs. last bir 16	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	ay, Year)	9. Birthi Cou	place (State or Foreign ntry) MD
	the Maryland 28a-f show	Director	Usuel Residence of 10a. State	10b. County		10c. City, Town		ORE					10d. Inside City Limits XXYes 2 □ No
	th with t		10e. Street and Nu 2412 LL1	imber EWELYN AV	ENUE			10f. Zip Code	213		10g. Citizen o	f What Cou	ntry?
9036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show diest Examiner must be motified at	by Funeral	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces? 1 Yes 201 If Yes, Give Year or Dates:				dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	o- 14. R	14. Race - American Indian, Black, White, etc. Specify: BLACK	
Maryland 21215-0036	~ × //4	Completed	Elementary/Seco	15. Decedent's Ed cify only highest gra ondary (0-12)	ucation de co <i>mpleted)</i> College (1-4or t		(Give life. L	OO NOT use retired	during most of work	ing	16b. Kind of Business/Indus		
nd 2	should be filed within and Mental Hygiene. marked other than imatic event, the M	Be Co	17. Father's Name	(First, Middle, Last)				STUDENT	18. Mother's Name	e (First, Middle		ATION	
ryla	Mer Mer arke	2	-	VINSON, S		401	A4.20			DA LAYN			
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 2412 LLEWELYN AVE., BALTO., MD 21213										Code)
Baltimore,	Pages 1 and 2 tent of Health nt: If item 27 I ry or other tra			'	Removal from State	cemeter	у, сгеп	sition (Name of natory or other place CEMETERY	(e)	Date 7 2005	20c. Location		
Balti	permit. Pages Department of I Important: If it any injury or o			uneral Service Licen	_	111 22	22.	Name and Addre		MES A.	MORTON	& SON	MARYLAND S F.H., INC AND 21217
	Fnysician /Medical Examiner		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	(Final	olications that caused one cause on each lin a	the death. Do note.	ot ente	er the mode of dyin	g, such as cardiac Hwo	or respiratory a	rrest,		Approximate Interval Batween Onset and Death
	led sit	niner	Sequentially list co cause. Enter Unde Cause (Disease or that initiated events	nditions, madiate orlying injury	b. — Oue to (or as a consequence of):								
8760,	cate be executed physician and the burial-transi	dical Examiner	that initiated events resulting in death) i	Last	Due to (or as	as a consequence of):							
.O. Box 6	death certifi e attending l id for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetel death		Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
Records, P	equires sen sign rould be	by	Part II. Other signif	icant conditions co	ntributing to death bu	ut not resulting in	the un	derlying cause give	en in Part I.	23e. Did t		tribute to th	e cause of death?
al Rec	The law ate has b page 2 sl	Completed										prior to con death?	sy findings available apletion of cause of
f Vital	ys di S	To Be	25. Was case referrexaminer?	17	Hospital: XXnpatie	nt 2 ☐ ER/Out	natient	3□ DOA Cthe	26. Place of Death er: 4 ☐ Nursing Hor			(0	
Division of	ding h. After fune	Certification: T	27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injur (Month, Day	y Year) 28b. Ti		28c. injury Work	at 2		now injury occur COLL C		+
Divi	Dir		3 ☐ Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju building, etc	all	eu	Δ	1	to Fran	Street and Number, State) 23	00 bl	OCK IUD ZIZI3
	Fur Ho	Medical	29a. Certifier (Check only one)	1☐ Certifying Phy Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and	death or inve	occurred at the time estigation, in my op	e date and place a	and due to the	onuco(a) and m		and .
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and	title of certifie				29c. License	number		29d. Date signe		

State Registrar 31. Date filed (Mcnth, Day, Year) 6 2005

cause of death (Item 23a) (Type, Print)
111 Penn Street Baltimore, Maryland 21201

29c. License number OCME

May 4, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Sitter of Ma Para Physics 8811 ment of Heart and Mental Hygiene

		•	For State Registrar	•	rtificate of Death	Reg.		1 12 1 6 6
	Physici.		Decedent's Name (First, Middle, Last) Lume 1	Vaughn			Day Year 24 2005	7:34 P·M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number, 501 Brisbane Road		4b. City, Town, or Location of Death Balto		4c. County of Death N/A	
	Funeral Director		216-78-0925 IXIM 20F	ge (In yrs. last birthday) Yrs. 46	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign ntry) Md
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County Md N/A	10c. City, Town or Lo	ocation			10d. Inside City Limits 17 Yes 2 □ No
	the M	recto	10e. Street and Number	Daito	10f. Zip Code	10g.	Citizen of What Cou	
	23a o	ai D	1311 Fulton Avenue		21217		U S A	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelip and Mental Hygiene. Department of Heelip and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show mith follow or other traumatic event, the Medical Examinar must be invitited at ange.	by Funeral Director	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes, Given Year or Dates:	No	Was Decedent of Hispanic Origin? (Splf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2√√2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	odent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16t	o. Kind of Business/Ir	ndustry
2121	d within r than	ошо	Elementary/Secondary (0-12) College (1-4or 9th grade N	5+)	elf Employed		Home Impro	ovement
nd	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Mai		
Maryland	hould d Men marke matic	ဥ	Mack Irvin Vaughn 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	Jessie ing Address (Street and Number or Rui	Mae Mitch		p Code)
Ma,	and 2 selth and 2 selth and 27 is		Patricia Joyner - Sister		Parkwood Avenue			
Baltimore,	Pages 1 and the ment of He ant: If Item		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State 1 □ Conation 5 □ Other (Specify)	Cedar Hi	matory or other place) 111 Cemetery 4-29	-2005 A1	c. Location - City or T	
Balt	Departi Departi Importa eny Inji		21. Signature of Funeral Service Licensee.	3	2. Name and Address of Facility M 4300 Wabash Ave		West to, Md 212	215
2	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	nots,	Approximate Interval Between Onset and Death			
68760,	rtificate be executed ng physician and as the burial-transit	dicai Examiner	that intitated events resulting in death) Last C. Due to (or a	s a consequence of):				
O. Box 6	ath cer	Physician/Medical		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	rery Day Year
rds, P.	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause given in Part I.		co use contribute to	. /
Il Records	The law ate hes b page 2 sl	Completed				24a. Was an autopsy performed	death?	opsy findings available ompletion of cause of 2 No
of Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpat	ient 2 ☐ ER/Outpatie	Other	th (Check only ope)	e 6 X Other (Speci	Niece's
Division of	fe fe	-	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident 28a. Date of In (Month, D			28d. Describe how	injury occurred	
DIVis	s after de si Directe ed in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of It building, 6	njury - At home, farm, st etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occu			
	To the within To the comp	M	29b. Signature and title of certifier	'N	29c. License number 7/30/2	29d.	Date signed (Month)	Oly, Year)
	1		30. Name and address of bersen who completed cause of	death (I)em 234) (Type	Print) ped ha	Botho.	1/1/2	1218
	Sta Regist		31. Date filed (Month, Day, Year) 32. F 3is MAY 0 6 2005	trar's Signature	food	"		

	2991 ild Wil	li		State of M. 23a.pt.II					•		_	5
	Physic	ian	Registrar 1. Decedent's Name (First, Middle, Last			Ceniii	cate of	Death	2. Date of D	makh		3. Time of Death
	/Medi			LIAMS					April		30 200	05 1021
	Exami	ner	4a. Facility Name (If not institution, give				-	r Location of Dea	ath	40	County of D	
			Franklin Square				Roseda				Baltir	
	Funeral Director		5. Social Security Number 6. S 212-54-2349 Usual Residence of Decedent	ex 7.Ag M∑M 2□F	e (In yrs. last b		Under 1 Year onths Days	Hours Mi				Birthplace (State or Fore Country) MARYLAND
1	land		10a. State 10b. County		10c. City, Tox	wn or Locatio	in					10d. Inside City Lim
	e Marylan 3a-f ehow	ctor	MARYLAND BALTIMO	RE	1	BALTIM	ORE					1 □Yes XXI
	라 다 6 2 2	e e	10e. Street and Number			10	0f. Zip Code			10g. Ci	tizen of What	: Country?
	ath w	ra	6032 NAHANT ROAD				21206				.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow any injury or other traumatic event, I're Madical Examire roual te naillied at ance.	by Funeral Director	Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Decedent of F s, specify Cub res 2 No	lispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	0-		m <i>er</i> ican Indian, /hite, etc. LACK
ŏ	2 hou	ed	15. Decedent's Ed	lucation	168	a. Decedent's	S Usual Occup	ation		16b. i	(ind of Busine	
21215-0036	vithin 72 ne. han "na e Madii	Completed	(Specify only highest gra	de completed) College (1-4or :				during most of w	rorking		ST FOO	
'n	led v tygie her t		9th grade 17. Father's Name (First, Middle, Last)		L	ABORER		19. Mothor's N	ame (First, Middle			DS
ä	be for	Be									i Sumame)	
Maryland	hould d Me mark matic	2	BERNARD WILLIAMS 19a. Informant's Name/Relationship (Type Print)	19	h Mailing Ac	Irines (Street		IUS JOHN: Rural Route Numi		or Town Stat	e Zin Code)
<u>s</u>	d2s than than trau											
e,	1 an Heal am 2		Robinette Onyeise 20a. Method of Disposition	/Sister	20b. Place	of Disposition	(Name of	1	Ltimore, Date	T		Z I Z U 6 or Town, State
Baltimore,	Pages ment of ant: If it ury or c		1 ☐ Burial 2 🖾 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			ery, cremator CREMA	y or other plac TORY		-05-05	BAL'	TIMORE	, MARYLAND
Balt	permit. Departimport. any inj		21. Signature of Funeral Service Licen	S ee	7	22. Na WIL 120	me and Addre LIAM C 6 W NO	ss of Facility BROWN RTH AVEN	COMMUNITY NUE	Y FUI	NERAL I	HOME P.A.
	Physician /Medical Examiner	er	28a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Hyperte		Athero			iovascul)isease	Interval Between Onset and Death
	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence	9 of):				•		
P.O. Box	The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal deat		ppic pregnancy er (specify)				23d. Date of Month	delivery Day Year
ds, ห	uires that the de signed by the a Id be detached f	þ	Part II. Other significant conditions of Chronic Alcohol		ut not resulting	in the underly	ying cause giv	en in Part I.				e to the cause of death? Probably 4 □Unknov
Records,	The law requir cate has been si page 2 should	Completed								opsy om <i>e</i> d?	prior death	autopsy findings availab to completion of cause o
VItal		CO	25. Was case referred to medical					26 Place of D	eath (Check only	2 No	1) Y	'es 2□No
5	Physician: this certificanal director, I	To B	examiner? 1 ∑Yes 2 No	Hospital: 1 ☐ Inpatie	ent 216 ER/O	Outnationt 3	DOA Oth	oc	Home 5 □ Res		6 ∏Other /S	ineciful
			27. Manner of Death	28a. Date of Inju	rv 28b.	. Time of	28c. Injur Wor		28d. Describe			pecity)
DIVISION	Attanding F ar death. rector: After by the funera	Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Injury N	1 1 🗆	k? Yes 2□No	29f Location	/Stroot or	ad Number or	Rural Route Number,
2	s after all Direct all	Certif	4 ☐ Homicide determined	28e. Place of Inj building, et			actory, office		City or To			nulai noute ivalliber,
	To the Hospital or Attanwithin 24 hours after deating the Funeral Director: To the Funeral Director: completely filled in by the	Medical		ysicien: To the best tiner: On the basis of and manner sta	f examination a							
	Fo th Within Fo th	Me	29b. Signature and title of certifier	A	0		29c. Licens	e number		29d. Da	te signed (Mo	onth, Day, Year)
•	, , , , ,		Valiet	as A	7		OCME			Ma	y, 1,	2005
			30. Name and address of person who	completed cause of d				et. Balt	imore, M	(arv1	and 21	201
	Sta		31. Date filed (Month, Day, Year) MAY 0 6 2	32. 5 gistr	ar's Signatur	Ans	D	,		 y 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** IRACY CHARISSE WIGGINS Mai /Medical Ab. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner lar ylano NA brenera Date of Birth (Month, Day, 2 - 30 · 1 Birthplace (State or Foreign Country) If Under If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Year 8. 9. 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🛣 F 32 MD 219.88.0479 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f ahow 10a State 10b. County 10d. Inside City Limits 1 No 2 No NA BALTIMORE MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 23g or W. MOSHER STREET USA 21216 Funeral Itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status the Medical Examiner 1 Yes 2 No 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC 11/14 GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) if Health and Mental BERTHA DINKINS ALPHONSO ပ WIGGINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (MOTHER) BERTHA LEWIS W. MOSHER ST-BALTO. MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o ō 1 R Burial 2 Cremation 3 Removal from State 05.06.05 RANDALLSTOWN 4 ☐ Donation 5 ☐ Other (Specify) KING PARK 21. Signature of Fune I Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO, NATL' PIKE, BALTO. MO an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Retween Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Septicemia **Examiner** 1100000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Ician/Medical attending properties of the second IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown Year 4☐Pregnant at time of death 5 Other (specify) the Physi 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 4 Unknown 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Nes 2 □ No 24a. Was an page 2 autopsy performed? certificate 2 No Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 1 🗌 Yes 2 **X**No 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 Tes 2 No hours after death. investigation within 24 hours after death

To the Funaral Diractor: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29c. License number 29b. Signature and title of certifier anjland Greneral

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2005

32. Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month WOOLFORD **Physician** SATHERING 2005 11.45A.M mar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTHWEST RANDALLSTOWN HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2**万**F 217.26.1917 80 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 show any injury or other treumetic event, the Madigal Examement must be tacilitied at 1 XYes 2 □ No BALTIMORE MD N Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code KINCHELOR 21202 6725 AVENUE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 🕅 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondary (0-12) NURSE HOME NURSING 121H GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY / IHOMAS VIOUA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE. BERNARD WOOLFORD BALTO. 6725 KINCHELOR MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State MO. NATL 05 · 05 · 05 4 ☐ Donation 5 ☐ Other (Specify) LAUREL, MO 21. Signature of Funeral Service Incensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALIO, NATE PIKE, BALLO, MO he mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Mon Smell (ell Conch oma Surgician) Consett and Death 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** reary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown ned by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be o durac ter 2 **N**0 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? certificate has page 2 1 Tes 2 No or Attending Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification; To 1 Tes 2 N this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funerel C 1 cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) May 18 2005 D54288 MO 30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Name Young)

(Name And Address of person who completed cause of death (Item 23a) (Type, Print)

(Name Young)

(Name And Address of person who completed cause of death (Item 23a) (Type, Print)

(Name And Address of person who completed cause of death (Item 23a) (Type, Print)

(Name And Address of person who completed cause of death (Item 23a) (Type, Print)

(Name Young)

(Name And Address of person who completed cause of death (Item 23a) (Type, Print)

(Name Young)

(Name Young)

(Name And Address of person who completed cause of death (Item 23a) (Type, Print)

(Name Young)

(Name And Address of person who completed cause of death (Item 23a) (Type, Print)

(Name Young)

(Name Yo

Registrar DHMH 17 Rev 1/2001

M State

Robert RJD •	Washir	ngt	Please Ty I - For Unpend Item 23 Registrar 1. Decedent's Name (First, Middle, Last)	-					_	giene Reg. No	-	3. Time of Death
	Physici /Medio		ROBERT WASHING	GTON					May 03,	Day)5 Year	2251P. M
	Examir		4a. Facility Name (If not institution, give stre Howard County Gener		+01		City, Town,	or Location of Deat		IIc	County of Death	
556	Funeral Director		5. Social Security Number LINK 6. Sex	7. Age	(In yrs. last birth	day) If I	Inder 1 Year nths Days	r If Under 24 Hrs		th Year)		place (State or Foreign intry)
77	the Maryland 28a-f show natified at	or	Usual Residence of Decedent 10a. State 10b. County N A		10c. City, Town		n					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ceme,	with the he or 28a-	Funeral Director	10e. Street and Number		STILL WILL	-	of. Zip Code			10g. Citi	zen of What Cou	intry?
ه	death wil	raiD	2819 ELGIN AVENU			12 144	21212		>===#. V== == N=		USA 14. Race - Amer	iona Indian
36	ours after rel', or Ite Exemite	by	11. Marital Status 12 1 ▶ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	. Was Decedent E Armed Forces? 1 ☐ Yes 2 Ø N If Yes, Give Year or Dates:			specify Cu	Hispanic Origin? (S ban, Mexican, Puer Specify:	to Rican, etc.))- 	Black, White	, etc.
1215-0	be filed within 72 hours ital Hygiene. Id other then "neturel", event, it e Madical Exa	Completed	15. Decedent's Educal (Specify only highest grade of	College (1-4or 5-	+)	Give kind	OT use retir	e durina most of wa	rking		nd of Business/li	-
a 2	filled w I Hygier other th	Be Co	GED 17. Father's Name (First, Middle, Last)	NIA			100	18. Mother's Na	me (First, Middle,) <u>C</u>
Maryland	2 should be filed and Mental Hygis Is marked other eumatic event, II	To B	ROBERT PERKINS						UASHINE			
Mar			19a. Informant's Name/Relationship (Type		19b. 281	·		NE. BA	ural Route Numbi	_	r Town, State, Zi 7) _	ip Code)
Je,	s 1 and of Health item 27 other to	1 3	20a. Method of Disposition		20b. Place of i	Disposition		1	Date Date		cation - City or T	own, State
Baltimore,	Page ment c ant: If ury or		1 ■ Burial 2 □ Cremation 3 □ Ren '4 □ Donation 5 □ Other (Specify)	noval from State	MT. 71	ON		05.1			TIMORE,	am
Balt	permit. Depart Import any in		21. Signature of Funeral Service Licensee	\mathcal{H}_{-}		VAUGI	ine and Addi	ress of Facility GREENE FI NATL PIKE	UNERAL	SERV	ICE 21229	
	Physician /Medical Examiner	er	Sequentially list conditions. b	Bronchop Due to (or as a		a com		ting Sarc				Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	·	a consequence of							
P.O. Box 68	ne death certif the attending hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	:. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		pic pregnan er (s <i>pecify</i>)			2	23d. Date of deli-	very Day Year
rds, P.	quires that the signed by ald be detact	by	Part II. Other significant conditions contri	ibuting to death bu	ut not resulting in	the under	ying cause g	pven in Part I.		obacco u Yes 2[the cause of death?
Reco	The law requir ate has been s page 2 should	Completed										opsy findings available ompletion of cause of
/ital	sicien: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?						ath (Check only o			
Division of Vital Records,	iding Physia Ih. : After this ca funeral dire	은	1 X Yes 2 No Hos 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	spital: 1 🔀 Inpatier 28a. Date of Injur (Month, Day	y 28b. Ti		28c. Inj.		dome 5 Resident			ify)
Divisi	in Pige	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc		m, street, f	actory, office	Э	28f. Location (City or To			ral Route Number,
	To the Hospitel within 24 hours a To the Funerel I dompletely filled	edicai (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of r: On the basis of and manner sta	examination and	death occ /or investig	urred at the gation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	within 2	N.	29b. Signature and title of certifier	Ellai	- md		0	nse number CME	1	May (e signed <i>(Month</i>	;
(C)	PHU LET		30. Name and address of person who com	LAD W	eath (Item 23a)	Penn	Stre	et Balti	more, Ma	ryla	ınd 2120	1
63	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		ar's Signature	Line	E)					

			State of Maryland / Department of Health and M		Z 11115	151,27
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Deat	eg. No.	3. Time of Death
	Physicia /Medic	al	MAE HELEN WORTHY- VAUGHN	05.04	Day Year 2005	2:10 PM
1	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 10WSON		BALTIMO	
	Funeral			8. Date of Birth		thplace (State or Foreign
	Director			8. Date of Birth (Month, Day, 02 · 09 ·	1933	SC
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryi -f sho	to	MD NA BALTIMORE			1 KN Yes 2 □ No
	or 28a	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
	I within 72 hours after death with the Maryland jiene. Than "neturel", or Items 23e or 28e-f show the Medical Examiner must be rediffed at	raiD	1515 APPLETON STREET 21217		US	4
	er des	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe ff Yes, specify Cuban, Mexican, Puerto ff	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	irs aft	by F			Specify: Bl	ACK
9	72 hou			na	16b. Kind of Business	/Industry
21215-0036	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	g	MTA	
	Hygier Hygier Ither th			/First Middle M		
Maryland	ed la la la la la la la la la la la la la	o Be	WILLIE WORTHY DORA BL	JRRIS	value or service of	
ary	s 1 and 2 should f Health and Men frem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	l Route Number	, City or Town, State,	Zip Code)
	1 and 2 Health tem 27 l				ND 2122	7 0
lore	<u>~ </u>		1 1 8 Burial 2 Cremation 3 Removal from State		20c. Location - City or	Town, State
Baltimore,		1	4 □ Donation 5 □ Other (Specify) CEDAR HILL 105.11. 21. Signature of Funeral Service License 2.2. Name and Address of Facility.		BALTO, MD	
Ba	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUI	NERAL S BAUTO.	MD 21229	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart ailure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Colo Reutan Cumuu			Onset and Death GEORS
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			4
		ē	Sequentially list conditions, if any, leading to immediate Desito (or as a sone-squence of):			
V	cuted	Examiner	Cause (Disease or injury that initiated events c.			
30,	cate be executed physician and s the burial-transit)
8760,	physic physic the b	edicai				
Box 6	leath certifica attending ph I for use as th	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of de	livery
	The law requires that the death certific. Ite has been signed by the attending pl page 2 should be detached for use as t	Physician/M	1		Month	Day Year
P.0	that the de led by the detached	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute t	the cause of death?
Records,	uires I signe Id be d	d by	â	1 □ Ye	es 2. 1 No 3 □ P	robably 4 Unknown
00	w requir s been s should	iete	9	24a. Was a		utopsy findings available
Re	The lavate has	Completed	Be la la la la la la la la la la la la la	autops: perform		completion of cause of
Vital	slcien: T certificat rector, pa	Bec	U 25. Was case referred to medical an examiner?			
of	this al di	7	1 Yes 2 MNo Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Hon		ence 6 X Ther (Spe	city) Noupla
On O		tion	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at 28c. I	200. Describe no	W Injury occurred	
Division	Attending or death.	ertification;	2 Action 2 Action 2 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2 4 Homicide 4 Homicide 4 Homicide 4 4 Homicide 4 4 4 4 4 4 4 4 4	28f. Location (Str City or Town	reet and Number or R	ural Route Number,
ā	itel or Att rs after d el Direct led in by	Cert	Dulluling, etc. (Specify)		.,	
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	edical	29a. Certifier (Check only one) (Check one) (Check only one) (Check one) (Check only one) (Check one) (Ch	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me		25	9d. Date signed (Mon.	h, Day, Year)
)		11,	1 (1) (auno	· ·	VAY 4.	2003
	6	16	29b. Signature and title of certifier 29c. License number 29c. License	Baltin	one mo	21204
	Sta	te	e 31. Date filed (Month, Day, Year) 22 Begistrate Signature	- 0 - 1		,
	Registr		MAY 0 6 200 plantes At Ag			

05.04.

UAUGHN, KINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician WALTRON 2:27 PM MICHAEL JOSEPH 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner THE JOHNS HOPKINS BALTIMOIRE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2□F 234-72-215 WINGINIA -31-47 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show treumatic event, the Medical Examiner must be notified at CHARLESTON 1 Yes 2 No KANAWHA **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Items 23a or 25309 202500 S.A. filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 0 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then " Elementary/Secondary (0-12) College (1-4or 5+) PALESMAN INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event 2008. Be LARLOTTE JALDRON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 202 SouthERN AINE TRAIL CHARLESTON WV 25309 Angela M. Watoron. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locati n - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State MADEWOOD CEMETERY ELKINS W.V 5 ☐ Other (Specify) 4 Donation Fur rat Service Licens 21. Signal of Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY DAYS ACUTE /Medical Due to (or as a consequence of) **Examiner** HEPATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit CARDIOMYOF Due to (or as a consequence of Certification: To Be Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day been signed by the attershould be detached for Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown page 2 s

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been executed. P.O. Box 68760, Division of Vital Records. the þ completely

1	3 - Olikilowii							
	Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknow				
					24a. Was an autopsy performed? 1 □ Yes 2 🗗 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No		
	25. Was case referred to medical			26. Place of De	ath (Check only one)			
	examiner? 1 🗆 Yes 2 🛍 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ 1	OOA Other: 4 Nursing	Home 5 Residence 6	i ☐ Other (Specify)		
	27. Manner of Death 12 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury	y occurred		
	3 Suicide 6 Could not determined		ome, farm, street, factory)	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			

ddress of person who completed cause of death (Item 23a) (Type, Print) MITHANI NONTH SU WALL 600

RES-000

STREET

29d. Date signed (Month, Day, Year) .200S

WOLFE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

BAUTHERE MARY LAND ZIZST

State Registrar

29a. Certifier

29b. Signature and title of centifier

31. Date filed (Month, Day, Year)

32. Regis Ar's Signature 2005

			State of Maryland / Dep	artment of Health and N		ene 0 0 5	15429
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Delano Williams, Sr.		April	22 2005	02:53A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Washington Adventist HOspital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Takoma Park If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery	ace (State or Foreign
	Funeral Director		579-62-0726 11XM 2□F 56 Yrs.	Months Days Hours Min.	(Month, Day, Y	(ear) Count 1949 Washir	try)
			Usual Residence of Decedent		JAII. UZ		3
	arylar show	_	10a. State 10b. County 10c. City, Town or L MD Prince Georges Capitol	Heights			Od. Inside City Limits X□ Yes 2 □ No
	the M 28e-f	Director	10e. Street and Number	10f. Zip Code	106	g. Citizen of What Coun	
	3e or			20743		USA	,
	death me 2	Funerai	1204 Kayak Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America Black, White, e	
9	or Ite	y Fu	1 Never Married 2 Married 1 To Yes 2 No	1 ☐ Yes 2 ☐XNo Specify:	Tilouin, Otoly	Specify: Blac	
Ö	hours turel',	ed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dece	edent's Usual Occupation	14	6b. Kind of Business/Ind	
7	in 72 n "nai	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	ing	DD. Raile of Desiriossalle	ustry
212	d with giene.	шо	Elementary/Secondary (0-12) College (1-4or 5+) 12th. Mech	anic	S	elf Employe	·d
p	al Hyg	Bec	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Sumame)	
yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Iteme 23e or 28e-f show is marked other than "naturel", or Iteme 23e or 28e-f show reumatic event, Ite Macalcal Examiner must be notified at	2	Floyd Williams		Unknown		
Mar	12 sh h and 7 is m treum		1	ing Address (Street and Number or Rui G St. S.E. Washing			Code)
Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke other treumatic		20a Method of Disposition 20b. Place of Disp	osition (Name of		Oc. Location - City or Tox	wn, State
DE DE	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		1 XBurial 2 Cremation 3 Hemoval from State	n National 05-2	4-05	Arlington,	17 A
a Hi	mit. F partm sorter / injur		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Mar		Funeral Home	2
Ö	permi Depa Impo any is		DR Marshall	4217 9th. St. N.W.	Washingt	on, D.C. 20	
П			23a. Party. Enter the disease, or complications that caused the death. Do not en stock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	S			J. 1001 4.114 DOM.1.
	/Medical _, Examiner		Due to (or as a conseq +nce of):	Calassa			
	E 20	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Under yin. b. Due to (or as a consequence of):	Tennoe			
	outed ansit	Examine	cause Enter Underrying Cause (Disease or injury that initiated events				
,0	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):				
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	d				
9 X	eath certifica attending pl for use as t	//Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	ry
Вох	death e atter d for u	iciar	in the past 12 months? 1 Yes 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.0	that the death ed by the atte detached for	hys	9 ☐ Unknown		1		
ŝ	res tha igned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	1 10		icco use contribute to the 2 1210 o 3 □ Proba	e cause of death?
ord	w requir been si should	eted	Howme Diwied	(and onpally	1 ☐ Yes		
Vital Records,	9 - 9	Completed	Mo Reporte C		24a. Was an autopsy performe	prior to con death?	psy findings available appletion of cause of
la		e Co	25. Was case referred to medical	26 Place of Deal	1 ☐ Yes 25 th (Check only one)		2 □ No
	Phyelcien: this certific al director,	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatie	Other		ice 6 Other (Specify)
u of	ding Phyen. After this funeral di	n: T	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury 28b. Time (Month, Day Year)	of 28c. Injury at Work?	28d. Describe how	injury occurred	
Siol	Attending Phyelcien: r death. ector: After this certific by the funeral director,	catic	2 Accident investigation	M 1 Yes 2 No			
Division	ol or Att	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, lactory, office	City or Town,	eet and Number or Rural State)	Houte Number,
ш	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	aj Ce	29a. Certifier 1 Marcertifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cau	ise(s) and manner as sta	ated.
	the Hos hin 24 h the Fur npletely	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or in any manner stated.				
	To the To the Comp	Š	29b. Signature and title of certifier	29c. License number	290	d, Date signed (Month, D	Day, Year)
)	-1			1)43660		4-66-0	
r	l ,		30. Name and addresse of person who completed cause of death (frem 23a) (Type	DUSGO TFEX CA,	12y 16	CUIP 1	7122071
	Sta	to	31. Date liled (Month, Day, Year) 32. Registrar's Signature	And to	, V.		,
	Registr		31. Date liled (Month, Day, Year) 32. Registrar's Signature	Jacober			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Year Clara L. Wood 12: 30 AM 3 2005 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 11026 BirdRiverGroveRoad White MArsh
If Under 1 Year If Under 24 Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
April 23, 1941 6. Sex Social Security Number Birthplace (State or Foreign
 Country) **Funeral** Days Hours 1 □ M 2 € F Maryland 219-36-0968 64 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location orient: If item 27 is marked other than "naturel", or items 23a or 28e-1 show injury or other treumetic event, the Medical Examinat must be notified at MD 1 ☐ Yes 2 🛛 No Baltimore White Marsh Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11026 Bird River Grove Road 21162 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Macy's Elementary/Secondary (0-12) College (1-4or 5+) Customer Service 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menia Importent: If Item 27 is marked any injury or other treumetic events. George Bragg Elise Fortman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise MArtin /daughter 12 Cockpit Street Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition © Gurial 2 ☐ Cremation 3 ☐ Removal from State HollyHillCemetery 5/6/05 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, o shock, or heart failure. List plications that caused the de the one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final NON Months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the sequential of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month detached for in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 No 1 Tyes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number leted cause of death (Item 23a) (Type, Print) 30. Name in address of person who com 144 OVK 2. Registrar's Signature MAY 0 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY Physician 2:40 PM aren illiams Q14 " 2005 /Medical 4a. Facility Name (If Not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2**/**F 397.34-3540 Director WISCONSIN Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MA BALTIMORE es 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a by Funeral pranc 12. Was Decedent Ev Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any Injury or other traumatic event, The Media 900.9. Elementary/Şecondary (0-12) College (1-4or 5+) Baltimore eacher 12 Mar's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Micken eterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williams 10509 Long branch Nd-Date harles cckeysville 20b. Place of Disposition (Name of) 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5-8-05 Forest Hill. EVANS FUNERAL CHAPEL 22. Name and Address of Facility RD., TIMON UM MD 21093.
TEACEFUL ALTERNIATIVES FUNERAL-CREMATION CENTER 21. Signature of Funeral Service Licenses UNOBle 23a. Part 1. Enter the disease or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only die cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** d ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (c) as a consequence of). the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed ERUNINEUR 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 20 No 24a. Was an autopsy rmed? 2 X No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 2 No 1 Yes this Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day ear) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place I Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 61 D 33361 \mathcal{I}_{\prime} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

7601 OSLER DRIVE TOWSON, MARYLAND 21204

OLDERT DIGEROLAMO M.D. 7
31. Date filed (Month, Day, Year) Registrar's Signature

MAY 0 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:00 A.M **Physician** /Medical 4c. County of Death Eacility Name (If not institution, 4b. City, Town, or Location of Death ive street and number) Examiner BALTIMORE a RI 9. Birthplace (State or Foreign Country) MARYLAN If Under 1 Year If Under 24 Hrs. 7. Age In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Min. 2-28-948 1 M 2 F 212-28-948 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural', or items 23e or 28e-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral, or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No BALTIMORE Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 Dirmina nam Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) 12 omemaker hon 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be inthicum UNKNOWN ပ UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Are. MO 2634 Birmingham Detrounk yarah DALTIMORE or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 📈 Burial 2 □ Cremation 3 □ Removal from State MD 5-9-05 rosedale Sacdens of Faith Com. injury o 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BALTI MORE, MD 21234 21. Signature of Funeral Service Licensee any in EVANS FUNERALCHAPEL 8800 HARFORD RD or complic hone that caused the deat Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the shock, or he w Teas failure. List only on caves on each line Immediate Cause (Final Failure **Physician** disease or conditi resulting in death) /Medical Due to (or as a conquence of) Examiner Wal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death
9□ Unknown Day detached for 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? gignificant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Mocri 20 24a. Was an autopsy perform 2 X No 2 🗆 No 1 Yes 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Tyes within 24 hours after death. To the Funeral Director: After this 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1-1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier -IE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D L,1901 Hospital h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Sound for 5601 Loch Raven B h. Mirza 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 6 2005 Registrar

			1 - For State of Maryland / Dep Registrar	artment of Health and Menta	-
	Physic		JOSEDII ISAAC WIIKIES. S	14-	e of Death onth of Day 2005 Year 4.30 pm M
	/Medi Examii			4b. City, Town, or Location of Death Westminster	4:30pm M 4c. County of Death Carroll
	Funeral Director		5. Social Security Number 2.15-24-5251 6. Sex 7. Age (In yrs. last birthday, 77 Yrs.	Months Days Hours Min. (Mo	e of Birth nth, Day, Year) 28, 1927 9. Birthplace (State or Foreign Country) TN
	he Maryland 8e-f show	ector	10a. State 10b. County 10c. City, Town or Li	tminster	10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	3a or 2	Dir	10e. Street and Number 808 Deer Park Road	10f. Zip Code 21157	10g. Citizen of What Country? USA
980	d within 72 hours after death with the Maryland jiene. I'r than "naturel", or Items 23a or 28e-f show II's Medical Examirer must be notified at	by Funeral Director	3 ♥ Widowed 4 □ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yeif Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes 2 1 No Specify:	
Maryland 21215-0036	within 72 ho lene. Ithan "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Moderate	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Cenance Supervisor	16b. Kind of Business/Industry Manufacturing
yland 2	be file tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Elsie L.	Middle, Maiden Sumame)
	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other treumatic 00ce.		Mr. Steven Barnard (Nephew) 808 I	ng Address (Street and Number or Rural Route Deer Park Road Westmin	ster, MD 21157
Baltimore,	it. Pages intment of h intent: If ite njury or of		'4 □ Donation 5 □ Other (Specify) Sharon Ba	osition (Name of pater) Aptist Cemetery	20c. Location - City or Town, State West Friendship, MD
Ba	permit. Departm Importe any inju		A = A + A + A + A + A + A + A + A + A +	ATGHI FUNERAL HOME & C kesville, MD 21784 (4	HAPEL, PA (Box 195) 10)-795-1400
Į.	cate be executed // Medical whysician and pural-transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac or respira	Approximate Interval Between Onset and Death
.O. Box 68	ath certification in the or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐]Ectopic pregnancy] Other (specify)	23d. Date of delivery Month Day Year
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e	Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Vital Records,		Completed			. Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No
Division of Vit	ling Phys After this iuneral dii	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 1 Inpatient 2 FR/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		only one) Hesidence 6 □Other (Specify) cribe how injury occurred
DIVIE	oitel or Attendurs after death orel Director: lled in by the I	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	City	tion (Street and Number or Rural Route Number, or Town, State)
	To the Hospitel within 24 hours a To the Funeral (completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death 2 Medical Exeminer: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and due trestigation, in my opinion, death occurred at the	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
	To the To the To the Complete	Σ	29b. Signature and title of equifier Alexandrian	29c, License number D 2050 G	29d. Date signed (Month, Day, Year)
	17		30. Name and address of person who completed cause of death (Item 23a) (Type, I ATRICK URNES, AD SILITE IOZ	1000 Cilsuity Rd	Eldestry in 21784
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 6 2005 32. Registrar's Signature	At a	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04 10 2005 4:30 am James K. Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adelphi, MD Hill Haven Nursing Center NIA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□ F 95 428-26-5799 Director July 25, MS Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 27 Is marked other than "natural", or Itams 23a or 28a-f show traumatic avant, the Mcdical Examiner out the notified at Ellicott City 1 ☐ Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 Kun United States 3450 Huntsman Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 XX No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: lf Yes, Give Year or Dates: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Graphics Designs Veterans Admin. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last)

John Bucker Young Be Pages 1 and 2 should be finent of Health and Mental I shart: If itam 27 is marked o Mary Kennedy ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3450 Huntman Run, Ellicott City MD 21042 19a. Informant's Name/Relationship (Type, Print)

John Young / Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of Important: If its any injury or or one 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Asbury Cem. Tremont, 4/14/05 ' 4 ☐ Donation 5 ☐ Other (Specify) See Victor P. Doda, Jr22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Ave., Baltimore MD 21230

23a. Part. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Lice Approximate Interval Between Onset and Death 15 Yrs. Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructivbe Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown iis certificate has been si director, page 2 should i Be Completed Hypertension, Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 virsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 1 Yes 2**XX**00 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D31563 04/11/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Benner Lockwood Dr. 205 10801 Silverspring MD 20901 32. Registrar's Strature State

Registrar

		Į.	1- State amend item #3	ite of Marylar 11. per dvr	id / Depa g84 % &	artment of He	alth and M <i>eath</i>		jiene? () () [5 15435
Ī	Physicia	an	Decedent's Name (First, Middle, Last)	2:0		^		2. Date of Dea Month		3. Time of Death
	/Medic	al		RD ZIE	GLE			MAY	05 Zer	5 10:15 FTM
	Examin	er	4a. Facility Name (If not institution, give street UNIVERSITY OF MARYMM		FITTER	4b. City, Town, or Li BALTI			4c. County of De	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.B	irthplace (State or Foreign
	Director		216-42 - 8409	□ F 65	Yrs.	Months Days	Hours Min.	Month, Day March 1	, 10ai) L	MD
	land bw	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary I sh	tor	MD Worcester		Ocean 1	Pines				1 ☐ Yes 2 ☐ No
	th the or 28s	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?
	ath wi	ral	111 Central Parke Ea			2181			USA	
	ier de Items	Funeral	Ar Ar	as Decedent Ever in U med Forces?	.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
920	urs aft	þ	- Commercial If Y]Yes 2∏∑No ∕es,Give arorDates:		1□ Yes 2☑ No	Specify:		Specify: W	hite
2-0	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show he Medical Examinar must be motified at	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	16a. Dece	dent's Usual Occupation	on ring most of warkin	10	16b. Kind of Busines	s/Industry
12	vithin ne. han "	mple		llege (1-4or 5+)	life.	DO NOT use retired)				
in B	filed v Hygie other t		17. Father's Name (First, Middle, Last)	4		Engineerin:	g Manage: 8. Mother's Name		Engineer	ing
an	id be lental ked o	To Be	Charles Vincen	t Ziegler				Payne	,	
Maryland 21215-0036	2 shoutd and Men Is marke sumatic		19a. Informant's Name/Relationship (Type, Pr	int)	19b. Maili	ng Address (Street and	d Number or Rurai	Route Number	r, City or Town, State,	Zip Code)
χ Σ	and 2 ealth m 27		Mrs. Sharon Ziegler			Central Pa				
JOR	ages 1 and 2 should be filled within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Itsm 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	I from State	emetery, crei	esition (Name of matory or other place) w Mem. Parl			20c. Location - City o	
Baltimore,	permit. Pages 1 and Depertment of Healt Important: If Itsm 2? any injury or other in		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee						Sykesville	•
ä	Depermine Deperm		Duan L. K	tuff	`	AME and Address TAIGHT FUNI Sykesville	. MD 2178	34 (41()) — /95—1400	x 195)
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the deat se on each line.	h. Do not ent	er the mode of dying,	such as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	1 CUTE RESI	PIRATOR	y DISTRESS	SYNDRU	ME		2 MONTHS
	Examiner			Due to (or as a conseq NEUMONIA	uence of):	•				
	n =	ner		Due to (or as a conseq	uence of):		- <u>-</u>			
	ecute and trans	Examiner	that initiated events	Due to (or as a conseq						
68760,	v requires that the deeth certificate be executed been signed by the attending physician and should be detached for use as the burial-transit			oue to for as a conseq	derice or).					
687	ifficate g phys as the	edicai	d					V 1144		
ŏ	th cert tendin r use	an/M	230. Was decedent pregnant	es, outcome of pregna		Ectopic pregnancy			23d. Date of de	,
P.O. B	The law requires that the deeth cer tie has been signed by the attendir bage 2 should be detached for use	by Physician/N		Pregnant at time of d Unknown	eath 5	Other (specify)			Month	Day Year
٦.	that the by detac	y Ph	Part II. Other significant conditions contributi	ng to death but not res	ulting in the u	nderlying cause given	in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Vital Records,	quires							1 □ Y€	es 2□No 3□P	robabiy 4 [Unknown
ec0	25 8	Completed						24a. Was a		utopsy findings available completion of cause of
= H		Con						perform	ned? death?	s 2□ No
Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	l:^		Other	6. Place of Death			
	Phys this	. To	TE YES ZINO	. Date of Injury	ER/Outpatien 28b. Time of	IL SEL DON	4 Nursing Hom		ence 6 Other (Spa	ecify)
O	Attending Physicien: or death. ector: After this certific by the funeral director.	atlor	1 Accident 5 Pending investigation	(Month, Day Year)	Injury		s 2 No		. ,	
Division of	l or Attence efter death Director:	Certification:	2 □ Cuicido 6 □ Could not be □	Place of Injury - At he building, etc. (Specification)		eet, factory, office	2	8f. Location (St. City or Town	reet and Number or F n, State)	Pural Route Number,
	pltal o		29a. Certifier 1 Certifying Physicien:	To the heet of my kno	wladna daati	a coourred at the time	data and place at	nd due to the er	Juno(o) and manner of	c stated
	To the Hospital or At within 24 hours efter of To the Funerel Direct completely filled in by	edical	(Check only 2 Medicel Exeminer: O	n the basis of examina ad manner stated.	tion and/or in	vestigation, in my opin	ion, death occurre	d at the time, da	ate and place, and du	e to the cause(s)
	To t comp	M	29b. Signature and title of certifier			29c. License n		2:	9d. Date signed (Mon	th, Day, Year)
	\wedge	-	14/1	NO			600	/	MAY 05,	2005
	\		30. Name and address of person who complete JEFFREY LIU, MD	ad cause of death (Item 22 S 32. Registrar's Signa 6. 2005	n 23a) (Type, <i>G,REE</i>)	FINT B	BALTIMORI	E MI	21201	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	4 1 4				
	Registr	ar	MAY 05, 2005 MAY ()	6 20805	Kees .	AT RECOVER				

			1 - For Stete Registrar	State of Man		artment of H rtificate of L		F	Reg. No UU5	15436
-	Physici /Medio Examir	al	Decedent's Name (First, Middle, Las Edward 4a. Facility Name (If not institution, give	S.	Ama	atucci 4b. City, Town, or	Location of Deat	2. Date of Dea Month April	Day Year	1:25 p M
	Funeral Director		230 42 2383	7. Age (/	In yrs. last birthday) 97	Silver If Under 1 Year Months Days	Spring If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Omery rthplace (State or Foreign Junity) Italy
	th the Maryland or 28a-f show	Irector	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom 10e. Street and Number		Oc. City, Town or Lo				10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Country?
9600	72 hours after death with the Maryland natural; or Itams 23a or 28a-1 show dical Exarians front be indiffed at	ed by Funeral Director	520 Randolph Road 11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2XXVo If Yes, Give Year or Dates:		2090 Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Specify: U	ite, etc. Vhite
and 21215-0036	be filed within tal Hygiene. d othar than "	To Be Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Gaetano Amatucci		(Give	Jent's Usual Occupa kind of work done o DO NOT use retired lity Mana	furing most of wol) ger		Maiden Sumame)	e Dealership
Baltimore, Maryland	permit. Pagas 1 and 2 should Department of Health and Men Important: If item 27 is marka any injury or other traumatic:	T	19a. Informant's Name/Relationship (7) Samuel Amatucci / 20a. Method of Disposition 1 Amatucci / 20a. Method of Disposition 1 Donation 5 Other (Specify 21. Signature of Fune 1 Prive Licen	Son Removal from State	3527 20b. Place of Dispondermetery, cremetery, cremetery	Toddsbur sition (Name of natory or other place Heaven Ce	y Lane 0	Iney, Ma Date	r, City or Town, State, ryland 2 20c. Location - City o Silver Spr	20832 r Town, State
Ba	Physician /Medical Examiner	Je.	23a Part1. Enter the disease, or companded to the state of the state o	eu eu	e death. Do not ent a onsequence of):	1800 New	Hampshir	e Ave Si		Approximate Interval Between Onset and Death 1 Week
. Box 68760,	death certificate be executad e attending physician and of for use as the burial-transit	Physiclan/Medical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. Due to (or as a cod. d. 23c. If yes, outcome of the company of	pregnancy	Ectopic pregnancy			23d. Date of de Month	Divery Day Year
Records, P.O	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Completed by Phys	9 Unknown Part II. Other significant conditions of Chronic obstructi Congestive heart	ve pulmonar	•	, , ,	on in Part I.		an 24b. Were a	o the cause of death? robably 4 Unknown utopsy findings available completion of cause of
Division of Vital Record	ding Physician: After this certifica funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 EP/Outpatien 28b. Time of Injury	28c. Injury Work	or: 4 🗆 Nursing H	1 ☐ Yes ath (Check only or lome 5 ☐ Reside	2 No 1 ☐ Ye	TERM
Divisi	To tha Hospital or Attanovithin 24 hours after deatle To tha Funaral Diractor: completely filled in by the	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury building, etc. (3 ysician: To the best of m	Specify) ny knowledge, death	occurred at the tim	e, date and place	City or Tow	ause(s) and manner a	s stated.
•	To tha Ho within 24 To tha Fu completely	Medical	29b. Signature and title of certifier	liner: On the basis of ex and manner stated	amination and/or inv	29c. License	oinion, death occu	rred at the time, d	late and place, and du	e to the cause(s) th, Day, Year)
1	Sta Registr	1	30. Name and address of person who Richard Delaney, 31. Date filed (Month, Day, Year) APR 2 2 20	M.D. 392	h (Item 23a) (Type, 29 Ferrar: Signature	Print) 1 Drive W		Maryland	-	

			1 - For State Registrar			nd / Depa		t of H	ealth a		lental Hyg		20() 5	2 for	1.3
	Physici	an	1. Decedent's Name (First, Middle, L								2. Date of Dea Month	h Day	Y	ear 3	. Time of I	D'eath /
	/Medic		WILBUR A. AFFE				T				APRIL	20,	200.	5	2	А.М.
4	Examin	er	4a. Fecility Name (If not institution, g. HILLHAVEN NURS]		mber)				Location of	of Death			ounty of	Death GEOR	ORG	
	Euporol				7. Age (In yrs	s. last birthday)	If Under	ELPH 1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day					Foreign
	Funeral Director		117-12-0170	1 XM 2 ☐ F		37 Yrs.	Months	Days	Hours	Min.	(Month, Day JANUARY	Year)	918	. Birthplace Country) NEW	YORK	CITY
	p ,		Usuel Residence of Decedent		100.0	Sh. Town and										
	aryle shov	5	10a. State 10b. County	GEORGES	106. 0	City, Town or Lo									Inside City 1 🔀 Yes	
	the Marylen 28a-f show	ecto	MD PRINCE 10e. Street and Number	GEUNGES		ADELP	10f. Zip	Code				On Citize	an of Miles	at Country?		
	3a or	ום ו	8302 26TH PLACE					0783				U.S		it Country :		
	ms 2	nera	11. Marital Status	12. Was Dece	edent Ever in	U.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		I. Race -	American I	ndian,	
9	or ite	F.	1 Never Married 2 Married	Armed Fo 1 Tes If Yes, Giv	2 XNo		1 ⊡Yes		Specify:	i, Pueno	Aican, etc.)			White, etc.		
8	72 hours after deeth with the Marylend natural; or items 23a or 28a-f show deal Examinet must be molified at	d b	3 Widowed 4 Divorced	Year or D	ates:	. 1						1	Specify[W]			
21215-0036	n 72 "nat	iete	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usua kind of wo DO NOT us	rk dane d	turina mosi	t of work	ing	16b. Kind	d of Busir	iess/Industi	ry	
7	with iene. r then	Ho di	Elementary/Secondary (0-12)	College (1 5+	-4or 5+)	1	EARCH		,			FEDE:	RAL (GOVERI	NMENT	[
ğ	e filed Il Hyg othe	Se C	17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	e (First, Middle,	Maiden S	umame)			
<u> a</u>	Menta Menta	To E	CHARLES	AFI	FENS				CEL	IA		K	AUFMA	AN		
Maryland	2 sho		19a. Informant's Name/Relationship								al Route Number			ite, Zip Cod	de)	
e)	l and tealth im 27 ther to		RUTH AFFEN	S/WIFE	20h	Place of Dispo			ACE,		PHI, MD			T	Cara	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylet Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or, other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 ↑ 4 □ Donation 5 □ Other (Special Content of the Con		State JUI	EAN ME	MORIA	ther plac L GA	1	04/	22/2005	0	LNEY			
Balt	permit. Depert Import any inj		Corrected C.	Ltote	Temy	er D	2. Name ar ANZAN 170 R	d Addres SKY- OCKV	ss of Facilit GOLDB LLLE	y ERG PIKE	MEMORIA , KOCKV	L CH	APELS	INC 2085	<u>.</u>	
8760,	Death certificate be executed (Medical Examiner / Medical Examiner (Medical Examiner) (Me	licai Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	b. Huf	(or as a consector as	equence of):	1500		Fail			est,		Inte	proximate erval Betw set and D	een
.O. Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		oirth 2 ☐ Fe nant at time of	tal death 3[□Ectopic po □ Other (sp					23	3d. Date o	,	, Yı	ear
Ω.	requires that the de een signed by the e rould be detached t	by	Part II. Other significant conditions De mt. n. 4. a.	contributing to do	eath but not re	esulting in the u	inderlying o	ause give	en in Part I.	,	23e. Did to			ite to the ca		_,,,,
Il Records,	The law ete has b	Completed	Cerebrovasi	cular/	Accia	tent					24a. Was a autops perform	y	prio dea	re autopsy to comple th?	ition of ca	vailable use of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth		of Deatl	h (Check only or	e)				
of	S .5	- T	1 ☐ Yes 2 📉 No 27. Manner of Death	1 10		☐ ER/Outpatie		-	21		me 5 Reside			(Specify)		
OU	Attending Ph r death. sctor: After they the funeral	tion	1 Natural 5 Pending 2 Accident investigat		of Injury th, Day Year)	Injury	м	8c. Injury Worl 1 □	k? Yes 2□		254. 503615611	ow injury	occanoa			
Division of Vital	for Attendi efter death. Director: A	Certification:	3 Suicide 6 Could not determine	be 28e. Place	of Injury - Ating, etc. (Spec	home, farm, st	reet, factor	y, office			28f. Location (Si City or Town	reet and n, State)	Number	or Rural Ro	ute Numb	er,
_	To the Hospitel or Attenwithin 24 hours effer deat To the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Check only one) 1X Certifying l	Physician: To the baminer: On the band man	a best of my ki asis of examin	nowledge, deal nation and/or in	h occurred ivestigation	at the tin	ne, date an pinion, dea	d place, th occurr	and due to the c red at the time, d	ause(s) a ate and p	nd manne place, and	er as stated I due to the	i. cause(s)	
	To the To the To the To the Complex co	Me	29b. Signature and title of certifier	. 0			290	c. License	number		2	9d. Date	signed (#	Month, Day,	Year)	
			→ Loust	8	X			D00	05333	7		API	RIL 2	20, 20	05	
	12		30. Name and address of person wh	o completed caus	se of Jeath (Ite	em 23a) (Type	Print)							-		
			DOROTHY MAE S	EAY, M.D			CWOOD	DRI	VE, S	UITE	205, S	LVEF	SPR	ING.	MD 2	0901
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 2 20	05 Steel	legistrar's Sig	nature	Se s									

DHMH 17 Rev 1/2001

		1	_ State	State of Mary	yland / [Departme <i>Certifica</i>				iene •g. No. 2005	151.30
			1. Decedent's Name (First, Middle, Last)			001111100	210 07 1	Journ	2. Date of Deat	th	3. Time of Death
	Physicia /Medic	an	JOAN MC KEOWN	BURROUG	HS				APRIL	26, 2005	3:55A M
	Examin		4a. Fecility Name (If not institution, give st	reet and number)				Location of Death		4c. County of Dea	
A.				EY DRIVE			ITE der 1 Year	PLAINS	9 Date of Birth	CHARLE	
	uneral		5. Social Security Number 6. Sex	M STEF	In yrs. last bi	Yrs. Month		Hours Min.	8. Date of Birth (Month, Day JULY 4	Year) Co	thplece (State or Foreign ountry)
D	irector	h-	579-50-5352 Usual Residence of Decedent	6	55				OOLI -	1,1939 WA	SH.,DC
land	Mo Til	- H	10a. State 10b. County	1/	Oc. City, Tow	vn or Location					10d. Inside City Limits
Малу	fied	ţō	MARYLAND CHARLE	≧ S	WHIT	E PLAI	NS_				1 ☐ Yes ₹XNo
h the	or 28a-f show se notified at	Director	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of What Co	ountry?
th wit	23a c	a	4026 SPRING VALI	LEY DRIVE	3			0695		U.S.A.	
r dea	ems er m	Funerai	11. Walkar Status	Was Decedent Eve Armed Forces?	er in U.S.	13. Was De If Yes, s	cedent of H specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	, 14. Race - Am Black, Whi	
s afte	or I	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Ye:	2 X No	Specify:		Specify:	HITE
3 5	tural al Es	ed b	15. Decedent's Educ		168	a. Decedent's U	Isual Occup	ation		16b. Kind of Business	
in 72	Aedic	piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of life. DO NO	work done T use retire	during most of work d)	ing	DED DES	SERVE BD.
Z With	1	Completed	1 2	4	FO	OD SEE	RVICE				SERVE BD. VERNMENT
D effe	oth vent,	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
ITY INTO Z 1 Z 13-0030 should be filed within 72 hours after death with the Maryland	and wenter rigging a marked other than "natural", or items 23a aumatic event, the Medical Examinar must be aumatic event, the Medical Examinar must be	2	EDWARD S. MC KI				(2)	EVELYN		YER r, City or Town, State,	Zin Code)
N 01 6	is man		19a. Informant's Name/Relationship (Type	ne, Print)		-					
e, R	to recent an execute 1790 memory for It is Medical Executer must be notified at or other traumatic event, the Medical Executer must be notified at		WILLIAM BURROUG	JHS, SK	20b. Place	of Disposition (Name of		Date	20c. Location - City o	r Town, Stete 20695
Seg	important: If Item 2 any injury or other once.		1∑ Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	cemet	ery, crematory	or other pla	1	30-05	WAIDORE.	MARYLAND
Saltimor	ortant injury	1	*4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service License			MEMOR:		ess of Facility	30-03	WALDORI	HARLEMED
ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב	any ir		ml: 1 01	0 1				FUNERAL			
117	例		23a. Part1. Enter the disease, or complies shock, or heart failure. List only on	cations that caused the	ne death. Do	not enter the	node of dy	ng, such as Bardiac	of tespiratory ar	16,46	Approximate Interval Between
) Phi	ysician		Immediate Cause (Final disease or condition	Lyma	ham		Non-	- Wady L.	h,		Onset and Death
\ r \	ledical		resulting in death)	Due to or as a	consequence						,
Ex	aminer		Sequentially list conditions,)		0:					
\/B	si.	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e orj.					
xecut	al-trar	Examiner	that initiated events cresulting in death) Last	Due to (or as a	consequence	e of):					
Records, P.O. Box 68760, Carbo law requires that the death certificate be executed	hysicien and the burial-transit	dical E		1							<u></u>
on the	ig phy as the	edi									
Box eath cer	attending pt I for use as t	Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2	☐ Fetel dea		ic pregnanc	у		23d. Date of d Month	elivery Day Year
O. E	the att	sici	in the past 12 months? 1 ☐ Yes 2 Ñ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death	5 🗆 Othe	r (specify) _				
D. Tat	d by 1 Jetach	Phy	Part II. Other significent conditions cor	ntributing to death but	not resulting	in the underly	ng cause gi	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ds,	been signed by the atte should be detached for	d by							10	Yes 2.01 No 3□1	Probably 4 Dunknown
V requ	been	Completed							24a. Was	an 24b. Were	autopsy findings available
Re la	s has	d mc							autor perfo	ormied? death?	
	uficati or. pa	a	25. Was case referred to medical					26. Place of Dea			
ysicia Z	is cer direct	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ERV	Outpatient 3	DOA O	ther: 4 Nursing H	ome 5 Resi	dence 6 Other (Sp	pecify)
0 5	ter th	ü.	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injury (Month, Day		o. Time of Injury	28c. Inju		28d. Describe	how injury occurred	
SiOI	eath. or: Af the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			M]Yes 2□No	28f Location /	Street and Number or	Rural Route Number
Division of Vital Records,	fter d Sirect in by t	Certification:	4 Homicide determined	28e. Place of Injur building, etc.		, farm, street, fa	ctory, office)	City or To	wn, State)	Transfer Transfer,
Division of Vital To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phy	sician: To the best of	f my knowled	ige, death occu	irred at the t	time, date and place	, and due to the	cause(s) and manner	as stated.
e Ho	24 h e Fur letely	edical	(Check only 2 Medicel Exemi	on the basis of and manner stat	examination	and/or investig	ation, in my	opinion, death occu	irred at the time,	date and place, and d	ue to the cause(s)
Toth	within 2 To the I complet	Me	29b. Signature and title of certifier	//	1			nse number		29d. Date signed (Mo	nth, Dey, Year)
,			14 4)		77 00	33726		. /	_
	10		30. Name and address of person who	per leted cause of de	ath (Item 23	a) (Type, Print)		0 ~ 1 ~	Dh. J.	wo w-	Wa
	10		D. Larry Jenker	15 M. D. 32. Peristra	r's Signature	atora	nge t	Te. la	rmai	nD 200	70
	St Regist	tate	31. Date filed (Month, Day, Year) 6	2005		c has	K n				

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar 1. Decedent's Name (First, Middle, Las	State of Ma	aryland				ealth a	and M	ental Hy	Reg. No	21111	5 15	43
Physici /Medic Examin	al	Harold D 4a. Facility Name (If not institution, give 14609 Spruce Stre	eSales street and number) et		nett	Cres	sapto			Month OS	Oi 4c	County of	ear OS S.	ne of Deat
Funeral Director		5. Social Security Number 6. Si 214-07-5540 3 Usual Residence of Decedent	ex 7. Ag	92	Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da Sep 5,	191	2	Birthplace (St	ate or Fore
e Maryland Sa-f ehow Illieu al	ctor	MD 10b. County Allegan	у		Town or Lo		n							de City Lim
th with th	Funeral Director	10e. Street and Number 14609 Spruce Stre	et			10f. Zip		21502			10g. Ci	tizen of Wha	•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It a Madical Examinar matter inclination and once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ ! If Yes, Give Year or Dates:	No .	1	☐ Yes	2 ∐ №	Specify:	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.))-		American India White, etc. vhite	ın,
J within 72 h jiene. r than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5	5+)	16a. Deced (Give life. L Retired	kind of wo OO NOT us	rk done d se retired	luring mosi)	of working	ng		al #6	ness/Industry	
should ba filed ind Mental Hygi a markad other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Franklin Pierce E						18. Mothe	a Elle	(First, Middle en Orno	, Maider lorff	Sumame)		
and 2 sh saith and n 27 is m isr traum		19a. Informant's Name/Relationship (7 Robert Bennett	уре, Print) SON		19b. Mailin 2232	g Address 3 Mc	(Street a	nd Numbe en Hw	r or Rura /y	Route Numb Rawli	er, City o	or Town, Sta	ate, Zip Code) MD 2	2155
Pages 1: ment of He tant: If itan jury or oth	The same of the sa	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	cen	ce of Dispos netery, cren awn Me	emoria	ther place I Gard	dens	5	ate 5/4/2005	La'	ocation - Cit Vale	ty or Town, Stat	ME
Departr Departr Importa any inji		21. Signature of Funeral Service Licen	7A1	w	22					me, P.A. Cumber		MD 21	502	
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the attending physician and a large 2 should be detached for use as the burial-transit	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as b. Due to (or as c. Due to (or as d.		nca off).	174	28//	WW	c by	Cî (YNY	France Control of the		7	nery,
at the death certitica by the attending phitachad for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3	Ectopic pro Other (sp						23d. Date o Month		Year
w requires that been signad b should be deta	by	Part II. Other significant conditions of	entributing to death b	ut not resulti	ng in the un	derlying ca	ause give	n in Part I.		10		_	ite to the cause □ Probably 4	
	Completed	Anenia								24a. Was autor perfo 1 ☐ Yes	osy ormad?	prio dea	re autopsy findi r to completion th? Yes 2 \(\square\) No	ngs avail of cause
a = =	ition; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Day		NOutpatient Bb. Time of Injury		8c. Injury Work	r: 4 □ Nui	rsing Hom 2	(Check only one 5 Resident Res	dence	6 Other ((Specify)	
a Hospital of Attending is 24 hours after death. Funeral Director: After etely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At hom c. (Specify)	e, farm, stre					8l. Location (S City or Tox			or Rural Route i	Vumber,
within 24 hours after to the Funeral Discompletely filled in	Medical	29a. Certifier 1 Certifying Phyone) 1 Medical Example 2 Medical Example 2	ysician: To the best of iner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, a h occurre	nd due to the d at the time,	cause(s) date and	and manne place, and	er as stated. I due to the cau	se(s)
vithin 2 To the complet	Me	29b. Signature and title of certifier	luj Then				. License	number	318		29d. Da	11	Month, Day, Yea	,
Sta Registr	-	30. Name and address of person who of the same and address of person who do not be a same and address of person	-	•	E 1 7 0	ldtov	n Ro	ad-Ci	umbe	erland N	MD 2	1502		

			1- For State of Maryland /	-	artmen rtificate				-	giene Reg. No.	2005	15440
ı	Physici	an	1. Decedent's Name (First, Middle, Last) Patricia Ann Collins Be	rgs	traz	er			2. Date of De Month	Day	Year	3. Time of Death 0727 M
	/Medio		4a. Fecility Name (If not institution, give street and number)				Location of	of Death	Apri1	\neg	2005 County of Deat	
	Lxumii		Chesapeake Woods				idge				orche	ster
	Funeral Director		5. Social Security Number 6. Sex 149-32-4899 1□ M 2包F 7. Age (In yrs. last b. 63	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 8,	th ly, Ye <i>ar)</i> 1941	9. Bird Co N e	hplace (State or Foreign buntry) W Jersey
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov	wn or Lo	cation							10d. Inside City Limits
	a-f sho	ctor	MD Caroline		Den	ton						1 X Yes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It e Modical Ext., it referents be notified at once.	by Funeral Director	10e. Street and Number 902 B Gay Street		10f. Zip		629			_	zen of What Co	-
	death ms 23	neral	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Ame	nican Indian,
36	s after	y Fu	Armed Forces? 1 Never Married 21X Married 1 Yes 2 2X No If Yes, Give 2 Year or Dates:	1	irres,sped 1⊡ Yes 2				Hican, etc.)		Black, Whit Specify:	e,etc. White
9-9	2 hour	ted b		a. Dece	dent's Usua	d Occupa	ation			16b. Kir	nd of Business	
21215-0036	vithin 7 ne. han "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2		dent's Usua kind of wor DO NOT us nemak		turing mos)	t of work	ng	0.7	wn Hom	Δ
	Hygie other t	a l	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,			
Maryland	d 2 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic evant, tre Max	ToB	Walter C. Sprague						Marie			
Mar	and 2 sh salth and n 27 Is m		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Norman Bergstrazer/Spouse	b. Mailir 902	ng Address 2 B G	(Street a	snd Numbe Stre	er or Rura et,	al Route Numbe Dento	er, City or n , Î	Town, State, 2 MD 216	Zip Code) 29
ore,	of Hea			ery, crer	natory or o	ther plac	9)		Date		cation - City or	
Baltimore,	tt. Pag rtment rtant: I njury o		`4 □Donation 5 □Other (Specify) Gree		oro				04/05			
Ba	Depa Impor any ir	10	21. Signature of Funeral Service Licensee Mrustine M. Coale	- 4	2. Name an 216 N.			-	rampto ederals			Home, PA 632
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the condition of the condit	e.Sp	ireb	of dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death Misself
68760,	The taw requires that the death certificate be executed in the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the conseque	u (1):	7	3-27						ges
P.O. Box (that the death certifica ed by the attending ph detached for use as th	Completed by Physiclan/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death		Ectopic pro					2	3d. Date of del Month	iv <i>ery</i> D <i>a</i> y Year
	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting (eyebrovascular mysefficiency Chronic obstructive pulmon	in the u	nderlying ca	ause give	en in Part I				se contribute to ∃No 3⊟Pr	the cause of death?
of Vital Records,	ysiclan: The law requiscentificate has been director, page 2 should	complet	Chronic obstructive pulmon	my	disco	se			24a. Was autor perfo		24b. Were au prior to death?	utopsy findings available completion of cause of
Vita	iclan: certific ector,	Be	25. Was case referred to medical examiner?			Othe			(Check only o	опе)		
on of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	ition: To	1 Inpatient 2 ER/O	Outpatier Time of Injury	_	8c. Injun Work	42.00		me 5 Resi			cify)
Division	tal or Atters s after des	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	farm, str	eet, factory	, office			28f. Location (. City or To	Street and wn, State)	d Number or Ri	ural Route Number,
	he Hospi n 24 hour he Funer	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge of the control of the contro	je, deati ind/or in	h occurred vestigation,	at the tim in my of	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
)	To t withi To tl	M	29b. Signature and title of certifier Mallowy	w			number 2592	33		29d. Date	signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a Michael D. Crowley. M.D.			ewi1	d Av	ле.	East	o n .	MD 216	501
	Sta Regista		31. Date filed (Month, Day, Year) APR 2 9 2005 32 Registrar's Signature		31/4)			,		- •• •		

			1 _ State	artment of Health and Me <i>rtificate of Death</i>		2000
			Registrer 1. Decedent's Name (First, Middle, Last)		Reg	g. No. 3. Time of Death
	Physicia	an	Randall Hartland Baker		Month	Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April .	21 205 0040 M
	Examin	er	Washington County Hospital	Hagerstown		·
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year ff Under 24 Hrs. 8	3. Date of Birth	Washington 9. Birthplace (State or Foreign
	Director		214-76-3944 ^{1⊠M 2□F} 67 Yrs.	Months Days Hours Min.	(Month, Day, 1) Dec. 28,	Year) 9. Birthplace (State or Foreign Country) 1937 Maryland
	D		Usual Residence of Decedent		, , ,	1997 Hary Land
	how	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Se-f	cto	Maryland Washington Hagers			1 XX Yes 2 □ No
	or 2	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	s 23a	ā	1388 Marshell Street	21740		United States
	er de	nue	Armed Forces?	Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	y F	1 SSNever Married 2 ☐ Married 1 ☐ Yes 2 SSNo If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23a or 28e-f ehow with the Medical Exercites must be notified at	Completed by Funeral		edent's Usual Occupation	11	6b. Kind of Business/Industry
15	n n	plet	(Specify only highest grade completed) (Give	e kind of work done during most of working DO NOT use retired)	7	ob. Take of Doublood Modelly
25	d with giene	E	Elementary/Secondary (0-12) College (1-4or 5+)	(disabled)		n/a
b	othe othe vent,	a)	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma	aiden Sumame)
/lar	Vid by Vienta	To B	Raymond Baker, Sr.	Gladys K	ennedy	
Maryland	sho and l		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural i	Route Number,	City or Town, State, Zip Code)
≥ `	and ealth n 27			Lakeridge Rd. New		MD 21774
ore	of H Miter		20a. Method of Disposition 1 ☐ Burial 2 ॡ Cremation 3 ☐ Removal from State 20b. Place of Disposition cernetery, cree	osition (Name of matory or other place) April	^{te} 22,	0c. Location - City or Town, State
Ë	Pag ment ent:		`4 □Donation 5 □Other (Specify) Resthaver	n Crematory 2005		cederick, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f ehow any injury or other treumatic event, Ite Madical Exercities must be notified at ance.		21. Signature of Fundami Service License	2. Name and Address of Facility esthaven Funeral Se	rvices.	Skkot Cody P.A.
_	0 □ = 0		1/10/	<u>501 Catoctin Mtn. H</u>	wy Fre	derick, MD 21701
П			23a. Part Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			
	Physician		Immediate Cause (Final disease or condition and the condition and	R GASTROUNTISTU	MAC	Criser and Beauti
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	R BASTROUNTEST 11 HEMORRHA	AGE 4	ITH SHOOK JUYS
1		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	bed sit	Examiner	cause. Enter Underlying Cause (Disease or injury			
•	xecul and al-trar	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dicai E				
687	ficate g phy:	edic	0.			
Box	leath certifi attending i for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
	death certifi e attending id for use as	Physician/Me	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
0	that the deatled by the atte	hys	9 ☐ Unknown			
S, D	signed I	ру Р	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use combute to the cause of death?
ord	w requires that the been signed by th should be detache		Acust Ciroun NO NO	000°r	1 ☐ Yes	s 2
Record	aw as b	ompleted	ACUTE YUBULAR NEC	160717	24a. Was an autopsy	
æ	0 - 0	Соп	WOTH RENAL	FAILURIE	perform	ed? death?
Vital	Physicien: Th this certificate al director, pag	Be (25. Was case referred to hedical examiner?	26. Place of Death (Check only one)
of	Phyeic this or ral dire	၉	1 Yes 2 Hospital: 1 Latient 2 ER/Outpatie		e 5 🗌 Resider	nce 6 Other (Specify)
		on:	27. Man of Death 1 I Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	d. Describe how	v injury occurred
sio	Attending ir death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division	- 0	Certification:	4 Homicide detarmined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town,	eet and Number or Rural Route Number, State)
	spital ours ours serei filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	d due to the car	uco(a) and manner as stated
	24 h	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	d at the time, dat	te and place, and due to the cause(s)
	To the Hospital or within 24 hours aft To the Funerel D completely filled in	Me	29b. Signarure and title of gentifier	29c. License number	29	d. Date signed (Month, Day, Year)
			Make V Bull M. Personal Phys	ichus 1) 0004	1359	APR 21 200F
	\		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	00/1	111.01,000
	\		1208GRTBRULL 1459 POTOMAC	STREET ALAGI	ERITOU	IN MARYLAND
	Sta		31. Date filed (Month, Day, Year) APR 2 5 2005 32. Segistrar's Signature	Land :	. 5,5	21742
	Registi					

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend 1 tem 24a per mr 9843 5-5-05 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) a.k.a. Cloie 2. Date of Death Month Day **Physician** 2005 Chloe Virginia Croft May 1 10:58a [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northampton Manor Nursing Center Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth
Jun 8, 1924 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 264-11-2498 1 ☐ M 2 🛛 F Virginia 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, The Medical Exam set must be published at once. 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits Florida Indian River Vero Beach Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4475 First Street 32968 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shelton Archie Anderson Ethel Irene Dye 2 19a. Informant's Name/Relationship (Type, Print)
Samuel J. Croft/ Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4475 First Street, Vero Beach, Florida 32968 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 5/2/05 Smithsburg, Maryland 21. Sig at e of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD MOO706 106 East Church Street, Fred
23a. Part 1. Enter re disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his rt failure. List only one cause on each line. MO0706 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolus Hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the all 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Cerebral Vascular Accident 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4x Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours a To the Funerel C

29a. Certifier

29b. Signature and title of certain

Medical

State

Registrar

Ronald E. Miller, M.D., 4 Culwell Drive, Mount Airy, Maryland 21771-5310 31. Date filed (Month, Day, Year) 32. Paristrar's Signature 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D26499

29d. Date signed (Month, Day, Year)

May 2, 2005

			ForState_	State of Marylai		rtment of H		Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cert	incate of	Dealii	2. Date of De	Reg. No.	! 0 0 5 -	8. Time of Death
	Physicia			1. /	,	Come	- 0 V 0	Month	Day		M
	/Medic		ELIZABETE 4a. Facility Name (If not institution, give s				r Location of Deat	APRIL		2005 County of Death	1605
	LAGITIII		CHESTER RIVER		-		ESTERT			KENT	_
F	uneral		Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs		rth		place (State or Foreign
	irector		218-36-4610	M 2□xF 66		Months Days	Hours Min.	December	19, Year) 21. 1	938 M	aryland
pu	>		Usual Residence of Decedent	140.0							
aryla	show	5	10a. State 10b. County Maryland Queen		ity, Town or Loca Church					1	0d. Inside City Limits 1 Yes 2 No
he M	28a-f	Director	•	Affile 5	- ITUI CII						
with (a or i	吉	10e. Street and Number			10f. Zip Code	_		10g. Citi Uni t	zen of What Coul	tes of
eath	is 23	Funeral	214 Walnut Stree	⊇ t I2. Was Decedent Ever in U	1.C 12 W	2162					<u> America</u>
ter d	Item THE	Š	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	o-	 Race - Americ Black, White, 	
urs af	0, 1	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 (☐Yes 2☐MNo	Specify:			Specify:	
2 hor	"natural", or items 23a or 28a-f idical Examination was be restille	ted	15. Decedent's Educ	cation	16a. Decede	nt's Usual Occup	ation		16b. Ki	nd of Business/In	asian _{dustry}
hin 7	Margar L	ple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life. Do	nd of work done O NOT use retired	during most of wo	rking			
d wit	t a	Completed	12	4	ĸeç	istere urse	α			Medici	ne
VIGILIO & 1 & 1 & 1 & 1 & 1 & 1 & 1 & 1 & 1 &	s monwent rygon. I marked other than "natural", or items 23a or 28a-1 shov aumatic event, II a Madical Examitian i wat be multified at	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	, Maiden	Sumame)	
ping y		Tof	William Leslie				Berth	a Lou	ise	Cole	
S Sylver	ls m		19a. Informant's Name/Relationship (Typ	oe, Print) Husband	19b. Mailing	Address (Street	and Number or Ru	ıral Route Numb	er, City o	r Town, State, Zip	Code) 21623
and	item 27 Is marke		Henry Fletcher (Comegys	_ 214 W	alnut	Street,				
Pages 1	If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b.	Place of Disposi cemetery, crema	tion (Name of story or other place	ce)	Date	20c. Lo	cation - City or To	own, State
Pag.	lant: Jury		'4 ☐ Donation 5 ☐ Other (Specify)	De	enton C	Cemeter	y 5/1	/2005	Der	nton, M	aryland
Dall.	Important: If item 27 is any injury or other tra	H	21. Signature of Funeral Service License	711	22. M.C	Name and Addre	ss of Facility neral H	ome D	Δ		
م ا	1 = e OI		_ Tharles V.	000000	12	South	Second	Stree	t. I	enton,	MD 21629
			 Part1. Enter the disease, or complice shock, or heart failure. List only on 	cations that caused the dea e cause on each line.	ith. Do not enter	the mode of dyin	ng, such as cardiae	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition resulting in death)	META	SMIL	c /51	reast	Ca			Onset and Death
	ledical aminer		rosuming in obating	Due to (or as a conse	quence of):						
		5	S uentially list conditions bif any, leading to immediate	. Due to (or as a conse	quence of):						
ted	nsit	nln	Cause. Enter Underlying Cause (Disease or injury	200 10 (01 20 2 001100	4437100 01).						
эхөсг	al-tra	Examine	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):						
The law requires that the death certificate be executed	physician and the burial-transit	dical	d								
ificat	g phy as the	edic		2000							
Cert	attending p	lan/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn					2	23d. Date of delive	эгу
deat	e atte	icla	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of		ctopic pregnancy Other <i>(specify)</i>	′			Month	Day Year
i fi	detached	Physicia	9 Unknown	9□ Unknown							
o, a	signed t	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the und	lerlying cause giv	en in Part I.	23e. Did t	obacco u	se contribute to th	ne cause of death?
5 sinber	been sig							1 🗆	Yes 2	ZNo 3∏Prob	ably 4 Unknown
a v	2 33	ompleted						24a. Was	an	24b. Were auto	psy findings available
The	ate h	E O						perfo	ormed?	death?	npletion of cause of
ian:	iis certificate has t director, page 2 s	BeC	25. Was case referred to redical examiner?				26. Place of Dea				20.10
	. <u></u> O	2	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Oth	er: 4 🗆 Nursing H	lome 5 🗆 Resi	dence 6	Other (Specify	()
hysic	After tl funera		27. Mann Death 1atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injur	y occurred	
ng Physic	£ > :	at	2 Accident investigation			M 1 🗆	Yes 2 □ No				
ending Physici	Pos	13		28e. Place of Injury - At I	nome, farm, stree	et, factory, office		28f. Location (d Number or Rura	l Route Number,
or Attending Physical	irector: After the by the funeral	rtifle	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Speci	ny)						
vital or Attending Physic	ral Director	Certification;	4 Homicide determined	building, etc. (Speci							
Hospital or Attending Physical Abouts after death	Funeral Director	0	4 Homicide determined 29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemin	building, etc. (Speci ician: To the best of my kn er: On the basis of examin	owledge, death of	occurred at the tin	ne, date and place	and due to the	cause(s)	and manner as st	ated.
o the Hospital or Attending Physic, bin 24 hours after death	the Funeral Director	edical C	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Exemin	building, etc. (Speci	owledge, death of	stigation, in my o	pinion, death occu	and due to the	date and	and manner as st place, and due to	the cause(s)
To the Hospital or Attending Physician:	To the Funeral Director: A completely filled in by the fu	0	4 Homicide determined 29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemin	building, etc. (Speci ician: To the best of my kn er: On the basis of examin	owledge, death of	29c. Licens	pinion, death occu e number	and due to the	date and	and manner as st	the cause(s)
To the Hospital or Attending Physic, within 24 hours after death	To the Funeral Director completely filled in by the	edical C	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Special Country of the best of my knumber: On the basis of examinand manner stated.	owledge, death of ation and/or inve	29c. Licens	e number	and due to the irred at the time,	29d. Date	and manner as st place, and due to e signed (Month, 26/05	Day, Year)
To the Hospital or Attending Physic,	To the Funeral Director completely filled in by the	edical C	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who con	building, etc. (Special Control of the basis of examinand manner stated.)	owledge, death of ation and/or inve	29c. Licens D 3 (e number	and due to the irred at the time,	29d. Date	and manner as st place, and due to e signed (Month,	Day, Year)
To the Hospital or Attending Physic,	To the Funeral Directors To completely filled in by the	Medical C	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Special Country of the best of my knumber: On the basis of examinand manner stated.	owledge, death of ation and/or inve	29c. Licens	e number	and due to the irred at the time,	29d. Date	and manner as st place, and due to	Day, Year)

			1 - For State Registrar	State of	Marylan		irtment tificate			ınd M		giene Reg. No.	005	15444
	Dharaiai		1. Decedent's Name (First, Middle, Last)								2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medio		Anthony F. Cianfa	rini							April	23	2005	7:30 A M
	Examin		4a. Facility Name (If not institution, give s		iber)		4b. City, 1	own, or	Location o	f Death		4c. (County of Deat	h
			1326 Peters Corne						ville			Q	ueen Ar	nne
	Funeral		5. Social Security Number 6. Sex	M 2□F	7. Age (In yrs.		If Under	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)		hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	20.	76	Yrs.					Sept 9	1928	3 Mas	sachusetts
	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	f sh	ō	Maryland Queen A	nn s	C.	ıd1ersv								1 ☐ Yes 2∕ ☐ No
	1 the	Directo	10e. Street and Number	iiiie) 50	utersv	10f. Zip	Code				10g. Citiz	en of What Co	untry?
	3a o	ā	1326 Peters Corner	Road				216	668			USA		
	deetl ms 2	Funeral		2. Was Dece	dent Ever in U.	.S. 13. V	Vas Deced			gin? (Spe	cify Yes or No Rican, etc.)		4. Race - Ame	
ود	or Ita	F	1 Never Married 2 Married	Armed For	2 X No		Yes 2			, Puerto i	rican, etc.)		Black, White	
2	ural',	d by	3 ☐ Widowed 4 ₺ Divorced	If Yes, Give Year or Da	ites:		10103 2	₩ INO	эрвспу.				Specify: Wh	11 t e
<u>.</u>	72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced (Give	kind of worl	done d	uring most	of worki	ng	16b. Kin	d of Business/	Industry
2	within ne.	mp	Elementary/Secondary (0-12)	College (1	-4or 5+)		OO NOT us	e retired,)			_	1 3	1 -
N	filad within 72 hours after deeth with the Maryland Hygiene. Wher than "natural", or Itams 23a or 28e-f show with the Medical Examinar must be invitted at	ပိ	03 17. Father's Name (First, Middle, Last)			mech	anic		18 Mothe	r's Name	(First, Middle,		utomobi	те
ă	d all all	Be c		3									ourname)	
<u></u>	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28e-1 show eumatic event, the Medical Examinations in willied at	T _o	Augustine Cianfari 19a. Informant's Name/Relationship (Typ			19b Mailin	a Address	(Street a			th Spar I Route Numbe		Town State 2	Zin Code)
<u>8</u>	ith ar 1th ar 27 is 1reu		Helen Delores Alle		and		Rober					_	ide, MI	
9	Health tem 27 other tr		20a. Method of Disposition	11/ 111		Place of Dispo					ate		ation - City or	
9	Pages nent of int: If It		1 ☐ Burial 2 M Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from S		sapeake sapeake						Cho	ctor N	Maryland
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should I Department of Health and Men Important: If Item 27 is marke any injury or other treumatic: <u>once.</u>		21. Signature,of Funeral Service License	е	V	22	. Name and	Addres	s of Facility	y				
ñ	Par Imp		Menle CF	ley		F1 PC	eegle Box	and 160	Heli Green	fenb	ein Fun ro, MD	era1	Home,	PA
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that ca	aused the deat									Approximate Interval Between
3	Pnysician		Immediate Cause (Final disease or condition		ROSTA	-	CAN	100	,					Onset and Death
	/Medical		resulting in death)		or as a conseq		C/T/- (. 67						76/7/13
	Examiner		Sequentially list conditions, b											
	D ii	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (psence a ea to	uenes of):								
	ecute and I-trans	каш	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								-
8760,	rate be executed physicien and the burial-transit	alE		Due to (t	or as a conseq	derice di).								
687	the sate	dical	d											
	death certific e attending p ed for usa as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outo	come of pregna	ancy						2	3d. Date of deli	ivan
Box	leath atter	clar	in the past 12 months?	1 Live bi	rth 2 Feta ant at time of d	Ideath 3	Ectopic pre Other (spe						Month	Day Year
0	the c by the achec	lys	9 Unknown	9□ Unkno	wn		,	,,						
<u>a.</u>	The law requires that the de ste has been signed by the a bage 2 should be detached f	by Pi	Part II. Other significant conditions con	tributing to de	ath but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	obacco us	e contribute to	the cause of death?
g	w require been sig should b	De p									1 🗆 1	∕es 2□	No 3□Pr	obably 4 dunknown
000	aw re s bee	plet									24a. Was		24b. Were au	topsy findings available
Ĕ	The lav	Completed									autop perfo	rmed?	death?	completion of cause of 2 No
Vital Records,		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		12.130	
_	S D	To	1 ☐ Yes 2 No	ospital: 1 🗆 Ir	npatient 2	ER/Outpatien	t 3 🗆 DO	Othe	⁰ E: 4 □ Nui	rsing Hor	ne 5 Resid	dence 6	Other (Spec	city)
0	ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date o (Monti	of Injury h, Day Year)	28b. Time of Injury	28	c. Injury Work			28d. Describe I			
Division of	ttendii death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		res 2□N					
\leq	lor At after d Direct In by	Certification:	4 Homicide determined	28e. Place buildir	of Injury - At he ig, etc. (Specif	ome, farm, str y)	eet, factory,	office		1	28f. Location (S City or Tox		Number or Ru	ıral Route Number,
	pital urrs a arel [29a. Certifier 1 Certifying Phys	leines To the	h					N.				
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 12 Certifying Physical Exemination (Check only one)	ier: On the ba and mann	isis of examina	tion and/or inv	occurred a restigation,	it the tim	e, date and pinion, deat	d place, a th occurre	and due to the ed at the time,	date and	and manner as place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier		or otatoa.		29c.	License	number			29d. Date	signed (Monti	h, Day, Year)
	- > - ō		James fac	eco)	MO			000	2575	09			4/25	1
			30. Name and address of person who co			n 23a) (Type.	Print)							
			JAMES LACEY, 1	10 5	e of death (Item	SHINGT	ON.	AVE	CHE	STER	TOWN	MO	2167	20
	Sta		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa	ature	1 0							
	Regist	ar	APRSTE	100	1 3 800	S. A	S. C.	E.						

		State of Maryland / Dep	artment of Health and M rtificate of Death IM04	Mental Hygiene /25/05 Reg. No. 005 5445 2. Date of Death 3. Time of Death
Physici /Medi Examir	al	Murray Childs 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April 18, 2005 10:58 A M
Funeral Director		Northampton Manor Health Care 5. Social Security Number 219-18-0131 6. Sex 1 Max 2□ F 7. Age (In yrs. last birthday, 80 yrs.	Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Frederick 8. Date of Birth (Month, Day, Year) July 29, 1924 Maryland
Baltimore, Maryland ZIZID-0050 bermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examination to the notified at	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Married 3 Midowed 4 Divorced Page of Policy Services (1986) 1 Not of Policy Security only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Raymond Childs 19a. Informant's Name/Relationship (Type, Print) John Cox / Nephew 1324 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State	wrick 10f. Zip Code 21701 Was Decedent of Hispanic Origin? (Spull Yes, specify Cuban, Mexican, Puerforman Specify: Sedent's Usual Occupation a kind of work done during most of work done during most of work DO NOT use retired) 18. Mother's Name Myrtle	Specify: White 16b. Kind of Business/Industry Manufacturing e (First, Middle, Maiden Sumame) (unobtainable) ral Route Number, City or Town, State, Zip Code) ir, MD 21015 Pata 19, 20c. Location - City or Town, State
(60, Medical Physician and Purish Itansii	lical Examiner	23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or shart failure. List only one cause on each line. Chronic Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	22. Name and Address of Facility esthaven Funeral S	
I HECORDS, P.O. BOX BY The law requires that the death certifica ste has been signed by the ettending ph page 2 should be detached for use as it	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? performed? 1 Yes 2 No 1 Yes 2 No
Division of Vita or Attending Physicien: uter death. Director: After this certification by the funeral director.	Certification; To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospitel or Attend within 24 hours after deatt To the Funerel Director: Completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea Certifying Physici	29c. License number	
S: Regis	tate trar	Ronald E. Miller, M.D. 4 Cuitwell 31. Date filed (Month, Day, Year) APR 2 5 2005		ID 21771

DHMH 17 Rev 1/2001

		•	For State Registrar	State o	of Mai	ryland		rtment of F	Health and N Death		giene)	5446
	Physicia	an	Decedent's Name (First, Middle,	Last)		(A)	mand			2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,	nive street and nu	ımber)	Cy	la Company	4b. City, Town, o	or Location of Death	AFR	4c. County	of Death	()653 8 11
	Examin	er	SUBURBAN HOSP					BETHESDA	L.		MONTG	OMERY	Z
	Funeral			.Sex 1 □ M 2 X F	7. Age		ost birthday).	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, <i>Year)</i> 3, 1934	9. Birthp Cour	place (State or Foreign ntry)
	Director		107-28-5165 Usual Residence of Decedent				U			NOV. I.	3, 1934		
	arylan ehow	'n	10a. State 10b. County Maryland Montgo	mern			Town or Lo	cation				1	10d. Inside City Limits †√□Yes 2 □ No
	the M	Directo	10e. Street and Number	mery		ROCK	VIIIC	10f. Zip Code			10g. Citizen of	What Cour	
	th with 23a or	al DI	9600 Barkston Co	urt				20850			U.S.		
	er dea Itema rer m	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Dec	orces?		5. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Rac	ck, White,	can Indian, etc.
036	urs aft al', or	þ	3 ☐ Widowed 4 ☐ Divorced	1 □Yes If Yes, G Year or I	ive Dates:	,	1	☐ Yes 🌠 No	Specify:		Specif	y: Wh	ite
5-0	72 ho "natur	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usual Occur kind of work done	pation during most of world)	king	16b. Kind of B	usiness/ln	dustry
121	within iene.	dmo	Elementary/Secondary (0-12)	College 5	(1-4or 5+	•)		sociate			Sal	es	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itema 23a or 28a-f ehow any Injury or other traumatic event, It e Modical Examinar must be notified at once.	To Be C	17. Father's Name (First, Middle, L Samuel Rutta	ast)					18. Mother's Nam Gussi	ne (First, Middle, e Olive		ne)	
<u>a</u>	2 shou and N la mai		19a. Informant's Name/Relationshi		1				t and Number or Ru				
ق ح	1 and Health em 27 ther tr		20a. Method of Disposition		<u> </u>	20b. Pla		Barkston sition (Name of natory or other pla	Court, R	Date Date	e, Mary		20850 own, State
JO L	Pages ent of nt: If It		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		State	Juc	metery, cren lean M	em. Gard	ens 4/22	/2005	Olney	, Mar	yland
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service L	. Xto	ttle	mer	E I	Name and Addr dward Sa 091 Rock	gel Funer ville Pik	al Dire	ction, i	Inc. Mary1	and 20852
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that	caused t	the sath	. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		INC		GHLO	~			15	3 /2 years
	Examiner				o (or as a	consequ	ence of): -	₹X					0
17/1	שָּלָ עַ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(ur as a	consequ	onea of).						
65	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a	consequ	ence of):						-
709	. # 2 #	cal	1	d									
4 89	eath certifica attending ph for use as th	Med	IF FEMALE:	23c. If yes, o	uteomo e		201				004 D4	ate of deliv	
16M	. ō o ō	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live	birth 2 gnant at t	Fetal ime of de	death 3	Ectopic pregnand Other (specify)	ру <u> </u>			onth	Day Year
2rMC	es that the death igned by the atte be detached for	Phy	9 ☐ Unknown Part II. Other significant condition	s contributing to	death bu	t not resu	ilting in the u	nderlying cause g	ven in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
	v requires that been signed should be del	ed by								1)20	Yes 2□No	3 ☐ Prol	bably 4 Unknown
E C	The law requires that the tee has been signed by the sage 2 should be detached.	Completed				_				24a. Was auto		Were auto prior to co death?	opsy findings available ompletion of cause of
[/]		e Cor	25. Was case referred to medical						26. Place of Dea	1 ☐ Yes	2 No	1 🗌 Yes	2 No
	- S S	To B	examiner? 1 Tes 2 No		Inpatier		ER/Outpatier	IL 3 DOM	ther: 4 Nursing H	lome 5□ Resi	dence 6 🗆 Oti		fy)
Si	ling Ph After th		27. Manner of Death 1 (Spilatural 5 Pending		e of Injur	Year)	28b. Time o Injury	Wo	ury at ork? ☐Yes 2 ☐ No	28d. Describe	how injury occur	rred	
2/1/y/C	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	ce of Inju	ry - At ho	me, farm, sti	eet, factory, office		28f. Location (City or To		ber or Run	al Route Number,
7	pital or	Cer						h occurred at the	time, date and place	and due to the	cause(s) and m	anner as	stated.
pol	n 24 ho	edical	(Check only 2 Medical E	xaminer: On the	basis of	examinat	ion and/or in	vestigation, in my	opinion, death occu	irred at the time,	date and place,	and due t	to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier	11					nse number		29d. Date signs	-	
	6		30. Name and address of person v	the completed ca	use of de	ath (Item	23a) (Tyne		-9675		BERLT	10,6	رټ,
			RMU V - T	BOCCIA	mI) 6	Ja 1	Rockins	60 D	BeTHE	M , M	3	<u> </u>
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 2	2005	legistra MAN	ar's Signa	ture A	celes			,		

_			For State Registrar	. 1040	State		and / Dep <i>Ce</i>	artme		ealth and		tal Hygie	ene 0 0 5	15447
	Physici		1. Decedent's Name Margare	et Cece		rry						Date of Death Month 04	/23/2005°°	3. Time of Death 3:30 AM
	/Medic Examin		4e. Fecility Name (h							Location of De	eath		4c. County of Dear	
			Atlantic 5. Social Security N		al Hospi		rrs. last birthday		Berlin	If Under 24 H	Hrs. R	ate of Birth	Worceste	
	Funeral Director		167-18-75		1 □ M 2 💢 F		86 Yrs.	Months			din. (Date of Birth Month, Day, Y	919	thplace (State or Foreign punitry) PA
~	and w		Usuel Residence of 10a. State	Decedent 10b. County		10c.	City, Town or L	ocation						10d. Inside City Limits
5-10	with the Marylands or 28a-f show	ector	MD	Worces	ster		Berlin							1 ☐ Yes 2 X No
Sim	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examirat must be notified at	Completed by Funeral Director	10e. Street and Nur 214 Ch	nber Iarlestor	n Road				ip Code 1811			100	g. Citizen of What Co USA	ountry?
3	er dea	uner	11. Marital Status		Armed	ecedent Ever i Forces?	n U.S. 13.	Was Dece If Yes, sp	edent of His	spanic Origin? n, Mexican, Pu	(Specify uerto Ricar	Yes or No- n, etc.)	14. Race - Ame Black, Whit	
30% ¥ 3036	ural; or i	d by F	1 ☐ Never Marri 3 🏿 Widowed		d 1 ☐ Ye If Yes, Year o	es 2 No Give r Dates:		1 🗆 Yes	2 X No	Specify:			Specify: W	nite
15-6	n 72 h "natu	lete		15. Decedent's ify only highest	grade complete		16a. Dece (Give	edent's Usi s kind of w DO NOT i	ual Occupa onk done di use retired)	tion uring most of t	working	16	b. Kind of Business	Industry (Industry
212	d within giene. or than	mo	Elementary/Seco 10	ndary (0-12)	College	e (1-4or 5+)		nemal					Own Hon	ne
170 27-17 11and	uld be filed Mental Hygi arked other atic event.	To Be C	17. Father's Name ((First, Middle, La H. Gre						18. Mother's N			iden Sumame)	
Man	s 1 and 2 should f Health and Mer fem 27 is marke othar traumatic		19a. Informant's Na Robert F				214	Chai	rlesto	n Road	d Be	erlin,	Oity or Town, State, 2	
が Nore,	ages 1 a nt of Hei t: if Item		20a. Method of Disp 1 Burial 2 4 Donation	☐Cremation 3	3 Removal fro	om State V	b. Place of Disp cemetery, cre Vhitemar	osition (Na matory or Sh N	ame of other place lem .	Pk. 04	Date / 27 / 2	2005 Pi	c. Location - City or rospectvil	Town, State
ØJ.≓E	permit P Departme Importan any injury once.		21. Signature of Fu				2	2. Name a	nd Address	s of Facility	The	Burbag	je Funera	
	20280		2/a. Part1. Enter the shock, or hea	10 lellen d	ompliations the	at Jus Use o							MD 21811	Approximate
	Physician Physician		Immediate Cause (disease or conditio	(Final	/ .	n each line.	11	Ces-Y	Fo	ellere				Interval Between Or set and Death
8760,	/Medical Examiner physicien and physicien and the pruial-transit	ilcal Examiner	resulting in death) Sequentially list confirmed to improve the cause. Enter Under Cause (Disease or that initiated events resulting in death) to	nditions, mediate rhying injury isast	c	to (or as a con		Ca	diov	seular	P)iscar	·e	Yeers
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director. page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1⊜Liv 4⊜Pre	outcome of pre e birth 2 Fe egnant at time nknown	etal death 3	□Ectopic p					23d. Date of del Month	ivery Day Year
	uires that signed b	d by Pr	Part II. Other signif	/)	s contributing to		resulting in the	underlying	cause give	n in Part I.			cco use contribute to	
of Vital Records,	n: The law requir ficate has been si r. page 2 should	: Completed	25. Was case refer								_		prior to	stopsy findings available completion of cause of 2 No
ž	ysician: 1 is certifical director, p	To Be	examiner?		Hospital:	Inpatient :	2 ☐ ER/Outpatie	nt 3∐ D	OA Other	r	-	eck only one) 5 ☐ Residend	ce 6 □Other (Spe	cify)
on of	ding Phy h. After thi funeral	tion: T	27. Magner of Deat	h 5 🗌 Pending investiga		ate of Injury fonth, Day Yea			28c. Injury Work	at			injury occurred	
Division	spital or Attendi ours after death neral Director: A filled in by the fi	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Pla	ace of Injury - A	At home, farm, si ecify)	treet, facto				ocation (Stre	et and Number or Ru State)	ural Route Number,
_	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)	Certifying	xaminer: On the	the best of my e basis of exam nanner stated.	knowledge, dea nination and/or ii	th occurred	d at the time n, in my opi	e, date and pla inion, death o	ace, and di ccurred at	due to the cau the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signalure and	title of certifier	ø	/	. ~	29	c. License	number		29d	. Date signed (Monti	h, Day, Year)
			1/1/	Der	Carter	a.	nd) 4	ノム	826	7		41736	25
Cit	1,6		Ni Clicko	ess of person w	to completed c	Relu	Item 23a) (Type	Print)	12C	59 (exco.	Tole	Holing De	119944
	Sta Regist		31. Date filed (Mon	"APR"2"	2005 32	2. Filigistrar's S	ighature	bart					(

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Daff 02 2005 Martha Ellen MAY 0912 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign
Country) **Funeral** Months Oct 14, 1 □ M 2 🔽 F МĎ 1961 Director 213-88-2696 43 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show rai', or items 23a or 28a-f shov Examiner must be notified at Cresaptown V☐Yes 2☐No MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 14700 Wood Street death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: white Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ownhome homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Vernia (Hayes) Daff Ordy James Daff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Pages 1 and 2:
Department of Health ar
Important: if Itam 27 is
any injury or other trau MD 21502 mother 14700 Wood Street Cresaptown Vernia Daff 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/5/2005 Scarpelli Funeral Home, P.A. Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY DISTRESS SYNDROME /Medical Due to (or as a consequence of) **Examiner** ISCHEMIC BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit INCARCERATED VENTRAL HERNIA Due to (or as a consequence of) Box 68760, certificate be Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MORBID OBESITY autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred s Hospital or Attanding Pl 24 hours after death. s Funaral Diractor: After t Certification: 5 Pending investigation 1_Natural М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 D34362 MAY 2, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR.ROY CHISHOLM 924 SETON DRIVE CUMBERLAND, MARYLAND 31. Date filed (Month, Day, Year) State MAY 0 6 2005 Registrar

			1 - For State Registrar	State of Marylar	•	artment of H rtificate of L			Reg. No.		151.1.0
ı	Physici		1. Decedent's Name (First, Middle, Last Cooper Roland Di					2. Date of Month	, Day	AL ZOCE	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		2)	4b. City, Town, or	Location of			County of Death	-
	Funeral Director		214-32-0449	x 7. Age (In yrs. M 2□ F 75	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of (Month, Aug 1	Birth Day, Year) 3 1929	9. Birth Cou Mar	place (State or Foreign intry) yland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Caroline		ty, Town or Lo						10d. Inside City Limits 1 Y Yes 2 □ No
	or 28e	Directo	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	intry?
	s 23a	rai	13200 Greensboro	Road Lot#1 12. Was Decedent Ever in U	15 142 1		639	-2 /0		.S.A. 14. Race - Ameri	- Indian
980	urs efter de al', or item	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, I	n: (Specify residing Puerto Rican, etc.)		Black, White	etc.
21215-0036	within 72 hours efter death with the Maryland ene. then "netural", or items 23e or 28e-f show he Medical Erat in at triust be codified at	Completed	15. Decedent's Edi (Specify only highest grad	cation fe completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	ation furing most o	of working	16b. Ki	nd of Business/Ir	
2	Hygier Hygier ther th		07 17. Father's Name (First, Middle, Last)		fa	rmer	18 Mother's	s Name (First, Mic		dairy	
Maryland	fid be lental ked o	To Be	John Dixon				Myrt1e		0.0,	00	
ary	2 shou and M is mar eumat	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Street a	and Number	or Rural Route Nu	mber, City o	r Town, State, Zi	o Code)
Baltimore, M	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentat Hygiene. Importent: if item 27 is marked other then "netural", or items 23s or 28e-f show any figury or other treumatic event, the Marical Evaluation into the conflict and once.		Yvonne Marie Dixon 20a. Method of Disposition 1 X Burial 2 Cremation 3 I	20b. F	Place of Dispo cemetery, crer	sition (Name of natory or other place	θ)	Date	20c. Lo	cation - City or T	
THE THE	artmer ortent: Injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens			on Cemete: Name and Addres		oril 28 2	005 1	Millingt	on, Maryland
ñ	Deg any		Mean CF	lugh	F1e PO	eegle and Box 160	Helfe Greens	enbein Fu sboro, Ma	neral ryland	Home, P 1 21639	A
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the deal ne cause on each line.	th. Do not ent	er the mode of dying					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consect LIVER FA		-					
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (us as a consecu							
	acuted ind transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. HYPOTENS							
8760,	icate be executed physicien and s the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consec	quence ot):						
9	tificate ng phy: as the	Medic	15.555	d							
P.O. Box	he death certific the attending pl thed for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown	al death 3	Ectopic pregnancy Other (specify)			_	23d. Date of deliv Month	ery Day Year
	luires that the de n signed by the ild be detached	d by Ph	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.		id tobacco u		he cause of death?
Reco	The law requires that the ste has been signed by the bage 2 should be detache	Completed							utopsy erformed?/	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
ital		BeC	25. Was case referred to medical examiner?				26. Place o	of Death (Check or			
Division of Vital Records,	유 두 등	은	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 1 VInpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at Nurs		esidence (be how injur		(y)
Divisi	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)			28f. Locatio	n (Street and Town, State	d Number or Rur)	al Route Number,
	he Hospit n 24 hour he Funere stetely fille	edical (29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the tim vestigation, in my op	e, date and pinion, death	place, and due to occurred at the tir	the cause(s) ne, date and	and manner as s place, and due t	stated. o the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier			29c. License		2~		e signed (Month,	Day, Year)
1			> folialsold		- 00.1	200	5948	y /	4/2	24/05	
			30. Name and a of ess of person who con JOHN BOTS	ompleted cause of death (Iter 219 S.	Washi:	Print) ngton St.	Easto	on, MD 21	601		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	Card 1					

Dixon, cooper

		1- State of Maryland Registrar	d / Depa		ealth and N	Mental Hyg		005	15450
Physi	cian	Decedent's Name (First, Middle, Last)				2. Date of Dea		Year	3. Time of Death
/Med	dical	Theresa Lynn Dailey				April	I9	2005	1:06 A ^M
Exam	iner	4a. Facility Name (If not institution, give street and number) 10439 Assateague Rd.		4b. City, Town, or L Berlin	ocation of Death			unty of Death	
6		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		orceste	
Funera Directo		222-50-3038 1□M 2反F 43 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 12-1-61	Year)	9. Birthol De	ace (State or Foreign try) laware
yland		10a. State 10b. County 10c. City,	, Town or Lo	ocation				10	Od. Inside City Limits
Mar e-fsl	ctor	MD Worcester Be	erlin						1 ☐ Yes 2X No
th the	Funeral Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen	of What Coun	try?
23a	ig	10439 Assateague Rd.		21811			US		
ar de	nne	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13. Y	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - America Black, White, e	an Indian, atc.
hours after	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:			ecify: Whi	
hour fure	ed	15. Decedent's Education	16a Dece	dent's Usual Occupati	ion				
in 72 nin	piet	(Specify only highest grade completed)	(Give	kind of work done du DO NOT use retired)	ring most of work	ring	100. Kind (of Business/Ind	ustry
d with plane.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Home	maker			Own	Home	
d be filed antal Hyg ced othe	BeC	17. Father's Name (First, Middle, Last)			8. Mother's Nam	e (First, Middle, I			
uld by Menta	To E	Henry Kendall Phillips			Bertha l	Mitchell			
DESILITION CF. INTELLY STATES A LATE OF THE CONTROL OF THE MATTER PROPERTY. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show eny injury or other treumatic event, If Medical Exemination and item of the indifferent property.	ľ	19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street an					Code)
and and and n 27		Carl Henry Dailey		9 Assatea		, Berlin	, Md	. 21811	
Ses 1		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	ace of Dispo metery, crer	osition (Name of matory or other place)		Date	20c. Locati	ion - City or To	wn, State
Pag ment tent:		'4 □ Donation 5 □ Other (Specify)	vergre	een Cemet	ery 4-25	-05	Berl	in, Md.	
Dalling Dermit, Pages Department of Importent: If it	900	21. Signature of Funeral Service Licensee		2. Name and Address					Home
0 00500	a	11. Lun Demage		08 William				BII	
Physiciar /Medica Examine	il r	23a. Pall 1. Enter the disease, or complications that caused the death. shock, or flear failure. List drip one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a	ence of:	Failure)				Approximate Interval Between Onset and Death
The law requires that the death certificate be executed at the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen	ence of):						
wrequires that the death certifics been signed by the attending phenould be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of decent in the pregnant at time of decent in the pregnant at time of decent in the pregnant at time of decent in the pregnant at time of decent in the pregnant at time of decent in the pregnant at time of decent in the pregnant in the past 12 ☐ Fetal of the pregnant in the past 12 ☐ Fetal of the pregnant in the past 12 ☐ Fetal of the pregnant in the past 12 ☐ Fetal of the pregnant in the past 12 ☐ Fetal of the pregnant in the past 12 ☐ Fetal of the pregnant in the past 12 ☐ Fetal of the pregnant in the past 12 ☐ Fetal of the pregnant in the past 12 ☐ Fetal of the pregnant in the pregnan	death 3	Ectopic pregnancy Other (specify)			23d.	Date of deliver Month	y Day Year
that ned b	by P	Part II. Other significant conditions contributing to death but not result	tting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use	contribute to the	cause of death?
w requires the signer should be a	od b	Chronic Obstructive (un	9 0150	2ase	Yelly	s 2 🗆 N	o 3 ☐ Proba	bly 4 ∐Unknown
aw res	Completed	34.	(24a. Was a	1 24	4b. Were autop	sy findings available
The Is to ha age 2	шо					autops	ned?	death?	pletion of cause of
VICAL iclen:] sertifical ector, p	0	25. Was case referred to medical			26 Place of Deat	1 Yes 2	No No	1 🗆 Yes	2 L No
ysic is cer	0 B	examiner? 1 Yes No Hospital: 1 Inpatient 2 E	R/Outpatien	Othor		me S Reside		Other (Specify	
og Phy ig Phy ter this	n: T		28b. Time of Injury			28d. Describe ho			
Attending ar death. ector: Atte by the fune	atio	2 Accident investigation	mjury		s 2 No				
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the tuneral director, page 2	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office	Annua Annua	28f. Location (St. City or Town		umber or Rural	Route Number,
Hospi 4 hour Funer ely fill	edical	29a. Certifier (Check only color) (Check only color)	rledge, death on and/or in	occurred at the time, vestigation, in my opin	, date and place, nion, death occurr	and due to the ca	luse(s) and	I manner as sta	ited. the cause(s)
thin 2 the mplet	Med								
7 × × ×	_) ash in mi		DE TOURS	8750	2	اد از ز	yneu (Worlin, L	ay, rear)
			00=) 6	2/9	0100		4/	20/05	
1.4.2		29b. Signature and title of Pertifier 30. Name and address of person who completed cause of death (Item Grenn Aradon, MD 31. Date filed (Month, Day, Year) APR 2 5 2005	7716	+ Healt	hway I	DRIVE	Ber	In m	D 21811
S Regis	tate strar	31. Date filed (Month, Day, Year) APR 2 5 2005	& A	back					

DHMH 17 Rev 1/2001

Registrar

		Plea	ise Type or	Print in	Black I	Indelibl	e Ink.	Ensure A	II Copies	s Are	Legib	le.	
	for State		State	of Maryla				lealth and l	Mental Hy	/giene	е		
	Registrar				C	ertificat	e of	Death		Reg. No	000	F1.0	
an al	1. Decedent's Nam ROBERT	e (First, Middl	P.		ESTES				2. Date of D Month April	eath 22,	200	ear)5	3 Time of Death 12:00A. M
er			n, give street and no pice House				Town, o	r Location of Death	h	_	: County of nne Ar		el
	5. Social Security N 229–38–80	22	6. Sex 1 💢 M 2 🗆 F	7. Age (In y	rs. last birthda 68 Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D May10	ay, Year,	/	Coun	place (State or Foreign http) ington, D. (
	Usual Residence o	f Decedent 10b. County	,	100	City, Town or	Location							0d. Inside City Limits
tor	Maryland	1	e George':		Lanham	Location							1 ☐ Yes 2 No
ai Dire	10e, Street and Nu 8809 Br	ae Bro	ok Drive			10f. Zij	Code 20	0706		-	tizen of Wh		•
Completed by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed		ned Armed F	2 🗆 No		3. Was Dece If Yes, spe 1 \(\subseteq Yes	cify Cuba	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Black, Specify:	White,	
ietec	(Spec		nt's Education est grade completed)	(G.	cedent's Usu ive kind of wo e. DO NOT u	ork done	during most of wor	rking	16b. H	Kind of Busi	ness/Ind	dustry
omp	Elementary/Seco	ondary (0-12) 12	College	(1-4or 5+)		veyor	ise reme	<i>3)</i>		Pho	enix	Land	d Design
Bec	17. Father's Name	(First, Middle,	Last)					18. Mother's Nar	ne (First, Middle	, Maider	n Sumame)		
TOE	Clay War:	ren Est	tes					Mary Agr	es Schr	oell			
	19a. Informant's N					ailing Address	s (Street	and Number or Ru	ıral Route Numt	er, City	or Town, St	ate, Zip	Code)
	Josephine	e M. Ho	owell -Exe	cutrix	× 880	9 Brae	e Bro	ook Drive	Lanham	, Ma	rylan	d 20	0706
	20a. Method of Dis 1 XBurial 2 4 Donation	Cremation	3 □Removal from			sposition (Na crematory or Cans Cans Cans	other plac		Date /2005		ocation - Ci		wn, State Maryland
	21. Signature of Fe	ed U.	Boyen	w A	K 3	1400 PC	wde1	ss of Facility Sorgwardt MILL RO	Funera	l Ho	me. P	Ά	Land 20705
	23a. Part1. Enter to shock, or hea	the disease, o	r comp of tions that t only one cause on	caused the d	eath. Do not	enter the mod	de of dyir	ng, such as cardiad	or respiratory	arrest,	0.076		Approximate Interval Between

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medica

Physician

/Medica

Examine

Funeral Director

> Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

9 Unknown

Immediate Cause (Final

disease or condition resulting in death)

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

Respiratory Insufficiency

Due to (or as a consequence of):

Due to (or as a consequence of):

Metastatic Carcinoma

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

1 Yes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rectal Cancer

> 24a. Was an performed? 1 ☐ Yes 2 💢 No

24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No

Approximate Interval Between Onset and Death

Year

25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred

29a. Certifier

1 XNatural

2 Accident

3 Suicide

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier Musica Olllery 29c. License number D23743

29d. Date signed (Month, Day, Year) April 22, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin D. Weltz, M.D. 7525 Greenway Center Drive, #205 Greenbelt, Maryland 20770

State Registrar

31. Date filed (Month, Day, Year) APR 2 2 2005

6 Could not be



			1 - For State Registrar	State of	Maryland / De <i>C</i>	partment of I ertificate of			rgiene Reg. No.		
	Physici		1. Decedent's Name (First, Mic. Effie Mae El					2. Date of De Month April	path	Yeer	3 Time of Death 3
	/Medic Examir		4a. Facility Name (If not institute Suburban Ho	ion, give street and numb	per)	4b. City, Town, o	or Location of Death		4c. County of		13.44
	Funeral Director		5. Social Security Number 242-09-9759		Age (In yrs. last birthd	ay) If Under 1 Year Months Days		8. Date of Bir (Month, Da	th	9. Birthp Coun	Omery Nace (State or Foreign htry) th Carolina
	aryland show	2	Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. City, Town o	Location					0d. Inside City Limits
	with the M 3a or 28e-f	i Directo	Maryland 10e. Street and Number 1502 Univers	Montgomery		Silver Spi 10f. Zip Code 2090			10g. Citizen of W		1 ☐ Yes 2√∑No
36	72 hours after death with the Maryland naturel', or items 23a or 28e-f show areal Examiner must be maiffed at	by Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	12. Was Decede Armed Force 1 _ Yes 2	ent Ever in U.S. es? DXNo	3. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)		, White,	
21215-0036	within ane. then "	Completed		ent's Education nest grade completed)	16a. De (G (G iif	cedent's Usual Occupive kind of work done b. DO NOT use retire	during most of work d)	sing	16b. Kind of Bus	Polic	
Maryland 2	uld be filed vental Hygis rked other tic event, It	To Be C	17. Father's Name (First, Middle John Newton	e, Last)	, ben	OOT CIOSSI	18. Mother's Name	e (First, Middle, Clayton	Departme , Maiden Sumame		
	1 and 2 should be Health and Mental Ism 27 is marked of other treumatic even		19a. Informant's Name/Relatio William A. Mi			ailing Address <i>(Street</i> 9 Sutton W	and Number or Run	al Route Numbe			
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other		20a. Method of Disposition 1X Burial 2 ☐ Crematio 14 ☐ Donation 5 ☐ Other	(Specify)	20b. Place of Dicemetery, of Parklaw	sposition (Name of Frematory or other plan n Memorial	Park	Date Oril 25 2005	20c. Location - C	ity or To	wn, State
Bal	permit Depar Impor any in		21. Signature Funeral Service	Scere	ñ .	22. Name and Addre Francis J. 500 Univer	sith Bird	Funeral	Home In	C	MD 20901
	Pnysician /Medical		23a. Part. Enter the disease, shock, or heart failure. L. Immediate Cause (Final disease or condition resulting in death)	a Sepsi	n line.	enter the mode of dyli	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner pu	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Observations that initiated events	b. Bowel	Perforation as a consequence of:	on					
68760,	ificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or	as a consequence of):						
O. Box	death certifi e attending ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 Fetal death t at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	,		23d. Date Mont		ry Day Year
s, P	law requires that the de as been signed by the a 2 should be detached		Part II. Other significant condi	tions contributing to deat	h but not resulting in the	underlying cause giv	en in Part I.		obacco use contrib res 2 T No 3		e cause of death?
Vital Record	The lay ate has page 2	Completed							osy pri rmed? de	ere autop or to com ath?	psy findings available apletion of cause of
<u> </u>	Physicien: this certific ral director.	o Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	0 = EP/0	inn as por Oth	26. Place of Death				
ion of	nding Phy ath. r: After this e funeral d	ation: To	27. Manner of Death	28a. Date of I		of 28c. Injur	y at		dence 6 Other		
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	4 Homicoe	mined 289. Place of building,	Injury - At home, farm, etc. (Specify)			City or Tow			
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	one)	ring Physician: To the be al Exeminer: On the basis and manner	s of examination and/or	investigation, in my o	pinion, death occurr	ed at the time, o	date and place, an	d due to	the cause(s)
	20	~	29b. Signature and title of certif	muy		29c. Licens	5 7591		29d. Date signed (Month, D	ley, Year)
			1 24 12	n who completed cause of frey Muench,		e, Print) 8 Wisconsi	in Ave. #4	407. Bot	thesda M	ND 20	1814
100	Sta Registr	- 100	31. Date filed (Month, Day, Yea APR 2 2		istrar's Signature			-07, De	enesda, r	1D 2(,014

6:30 pm

4/20/05

		1 - State	State of Ma	-	epartment of C <i>ertificate o</i>		Mental H	201	The I had	pos.
		Registrer 1. Decedent's Name (First, Middle,	Last)		Jeruncale U	Dealli	2. Date of D	Reg. No.	3. Time (of Deal
Physicia		Emory Dougla	s Fleetwo	ođ			Month April	Day	Year 05 2345	
/Medid Examin		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town	, or Location of Deat		4c. County	2777	·
		Memorial				aston		Talb	ot	
Funeral			5. Sex 7. Ag 1 2 M 2 ☐ F	e (In yrs. last birth	Months Day		(Month, D	lay, Year)	Birthplace (State Country)	or For
Director		215-03-0096 Usual Residence of Decedent		90			Dct.2	8,1914	Marylan	.d
yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside (City Lin
Ba-f s	ctor	Maryland Talb	ot	Eas	ston				-XXYe	s 2 🗌
permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 Ie marked other then "naturel", or Items 23e or 28e-f show my injury or other traumatic event, ir a Modical Examirer must be notified at DDCs.	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V United	vhat Country?s o	f
death v ms 23e	eral	106 Earle Aven		Euroin II a	2160					me
ter de Item	-un	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Armed Forces?	1	 Was Decedent of If Yes, specify Co 	it Hispanic Origin? (S uban, Mexican, Puer	specify Yes or N to Rican, etc.)	0- 14. Race Blac	e - American Indian, k, White, etc.	
hours after turel', or Ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖫 N	lo Specify:		Specify	Caucasian	
72 ho	Completed	15. Decedent's (Specify only highest		16a. [Decedent's Usual Occ Give kind of work dor	cupation	dia a	16b. Kind of Bu		
within 72 ene. then "nai ne Medic	nple	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NOT use reti	ired)	rking	Tax	Assessmen	ts
filed w Hygier other th		11			Supervis				ernment	
d be fi	Be	17. Father's Name (First, Middle, La			-	-3-		e, Maiden Sumam	,	
should nd Men marke umatic	ဥ	Willia 19a. Informant's Name/Relationship	m Harvey		OOQ Wailing Address (Stre			sabella		
and 2 sho salth and n 27 le m		M. Elizabeth Fl)6 Earle					01
t Hea t Hea item other		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other p		Date	,	City or Town, State	
Pages net: If it		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe			on Cemete		0/2005	Dento	n, Maryl	an
permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Li	censee		22. Name and Add	dress of Facility uneral H	D	7	21	62
89 = 9		6 Kardes	. 11100	29_	Moore Fi	h Second	Stree	t Dent		
		23a. Part 1. Enter the disease, or co	amaliantiana that an car					C, DCIIC	OII FIRE / I	.an
		shock, or heart failure. List or	nly one cause on each lir	the death. Do no					Approxima Interval Be	ate etween
		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each lin	the death. Do no					Approxima	ate etween
Physician /Medical Examiner		shock, or heart failure. List or Immediate Cause (Final	a. Due to (or as	the death. Do not not not not not not not not not no	et enter the mode of d	lying, such as cardiad	c or respiratory	arrest,	Approxima Interval Be Onset and	ate etween
	i di	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequence of	et enter the mode of d	lying, such as cardiad	c or respiratory	arrest,	Approxima Interval Be Onset and	ate etweer
/Medical Examiner	mlner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as	the death. Do not not not not not not not not not no	et enter the mode of d	lying, such as cardiad	c or respiratory	arrest,	Approxima Interval Be Onset and	ate etweer
/Medical Examiner	Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as b. Due to (or as c. Ut	a consequence of	et enter the mode of d	lying, such as cardiad	c or respiratory	arrest,	Approxima Interval Be Onset and	ate etweer
/Medical Examiner	EX	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as b. Due to (or as c. Ut	a consequence of a consequence of	et enter the mode of d		c or respiratory	arrest,	Approxima Interval Be Onset and	ate etween
Medical pe executed of bulkarian and as the burial-transit	EX	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Ut	a consequence of a consequence of	et enter the mode of d	lying, such as cardiad	c or respiratory	arrest,	Approxima Interval Be Onset and	ate etween
Medical pe executed be executed by this private and as the burial-transit as the burial-	EX	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	a consequence of a consequence of ARMY a consequence of	tenter the mode of decided and	Notes that the second of the s	c or respiratory	ecost,	Approximatinterval Be Onset and Conset and C	ate etween Death
/Medical pe executed in the prical personned as the prical-transit as the prical-transit as the prical personned in the personned in the prical personned in the per	EX	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as d. Due to (or as	a consequence of a consequence of pregnancy 2 Fetal death	et enter the mode of d	tying, such as cardiac	c or respiratory	equoNEIM	Approximatinterval Be Onset and Conset and C	ate etween
tilicate be executed the many as the burial-transit as the burial-	EX	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as	a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death	tenter the mode of decided and	Notes that the second s	nca fly	23d. Date Mor	Approximatinterval Be Onset and Onse	ate ate the street of the stre
Ites that the death certificate be executed and and and be detached for use as the burial-transit	by Physiclan/Medical Exa	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as	a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death	tenter the mode of decided and	Notes that the second s	23e. Did	23d. Date Mor	Approximatinterval Be Onset and William Conset and	Year
requires that the death certificate be executed many been signed by the attending physician and hould be detached for use as the burial-transit	by Physiclan/Medical Exa	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as	a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death	tenter the mode of decided and	Notes that the second s	ra fly	23d. Date Mor	Approximatinterval Be Onset and Onse	Year death
aw requires that the death certificate be executed ss been signed by the attending physician and s should be detached for use as the burial-transit	by Physiclan/Medical Exa	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as	a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death	tenter the mode of decided and	Notes that the second s	23e. Did	23d. Date Mor	Approximatinterval Be Onset and Onse	Year death
law requires that the death certificate be executed to be some signed by the attending physician and to should be detached for use as the burial-transit.	Completed by Physiclan/Medical Ex	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	b. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as	a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death	tenter the mode of decided and	Notes that the second s	23e. Did	23d. Date Mor	Approximatinterval Be Onset and Onse	Year death
aw requires that the death certificate be executed with the death certificate be executed with a second by the attending physician and control of the detached for use as the burial-transit.	Be Completed by Physician/Medical Ex	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as	a consequence of a cons	st enter the mode of decided and state of the state of th	TANK 1.S A FECT The property of the property	23e. Did 1 24a. Was auto period of the control of	23d. Date More tobacco use contrades an 24b. Volume of 2 1 1 0 one)	Approximatinterval Be Onset and Onse	Year death
Physicien: The law requires that the death certificate be executed the state of the law requires that the certificate has been signed by the attending physician and the certificate has been signed by the attending physician and the certificate has been signed by the attending by the certificate has been signed by the attending the certificate has been signed by th	To Be Completed by Physiclan/Medical Ex	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underving Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as	a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death aut not resulting in the consequence of a consequence of pregnancy 2 Fetal death time of death aut not resulting in the consequence of a consequence of pregnancy 2 Fetal death time of death aut not resulting in the consequence of the consequence o	at enter the mode of decided and the mode of decided and the second given in Part I. 26. Place of Decorpton: 4 Nursing H	23e. Did 1 1 24a. Wea auto perfit 1 Yes atth (Check only)	23d. Date More tobacco use contraction of the contr	Approximatinterval Be Onset and Onse	Year death	
Physicien: The law requires that the death certificate be executed the state of the law requires that the certificate has been signed by the attending physician and the certificate has been signed by the attending physician and the certificate has been signed by the attending by the certificate has been signed by the attending the certificate has been signed by th	To Be Completed by Physiclan/Medical Ex	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Mannar of Death Natural 5 Pending	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death aut not resulting in the consequence of a consequence of pregnancy 2 Fetal death time of death aut not resulting in the consequence of a consequence of pregnancy 2 Fetal death time of death aut not resulting in the consequence of the consequence o	at enter the mode of decided and the mode of decided a	ncy 26. Place of Dead Date: 4 Nursing Higher at lork?	23e. Did 1 1 24a. Wea auto perfit 1 Yes atth (Check only)	23d. Date More tobacco use contrades an 24b. Volume of 2 1 1 0 one)	Approximatinterval Be Onset and Onse	Year death
Physicien: The law requires that the death certificate be executed to the law requires that the death certificate has been signed by the attending physician and real director, page 2 should be detached for use as the burial-transit	To Be Completed by Physiclan/Medical Ex	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as	a consequence of a cons	atient 3 DOA Datient 3 DOA Date of deciration of decirat	given in Part I. 26. Place of Dea Other: 4 Nursing Higher	23e. Did 1 24a. Wa. autoper 1 1 Yes ath (Check only tome 5 Res	23d. Date Mor	Approximation and interval Be Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset and Onset (Specify)	Year death
Physicien: The law requires that the death certificate be executed the state of the law requires that the certificate has been signed by the attending physician and the certificate has been signed by the attending physician and the certificate has been signed by the attending by the certificate has been signed by the attending the certificate has been signed by th	To Be Completed by Physiclan/Medical Ex	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as	a consequence of a cons	at enter the mode of decided and the mode of decided a	given in Part I. 26. Place of Dea Other: 4 Nursing Higher	23e. Did 1 24a. Weil autoperfit Yes 28d. Describe 28f. Location	23d. Date Mor	Approximatinterval Be Onset and Onse	Year death Junknote availa availa cause
Physicien: The law requires that the death certificate be executed the second that this certificate has been signed by the attending physician and second death of the second that the second	Certification: To Be Completed by Physician/Medical Ex.	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of the consequ	atient 3 DOA Doaltient 3 DOA The of ury M 11 death accurred at the	given in Part I. 26. Place of Decorate Cork? Yes 2 \(\) No se	23e. Did 1 1 24a. Wa autopent 1 1 Yes ath (Check only) tome 5 Res 28d. Describe	23d. Date More tobacco use contrement of the con	Approximatinterval Be Onset and William State of delivery on the Day state of the cause of a probably 4 were autopsy findings fror to completion of eath? Yes 2 No or (Specify) add	Year death Unknow a availate availate mber,
Physicien: The law requires that the death certificate be executed the second of the law requires that the certificate has been signed by the attending physician and injuries as the burial-transit.	Certification: To Be Completed by Physician/Medical Ex.	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of pregnancy 2 Fetal death at not resu	atient 3 DOA Doaltient 3 DOA The of ury M 11 death accurred at the	given in Part I. 26. Place of Decorate Cork? Yes 2 \(\) No se	23e. Did 1 1 24a. Wa autopent 1 1 Yes ath (Check only) tome 5 Res 28d. Describe	23d. Date More tobacco use contrement of the con	Approximatinterval Be Onset and William State of delivery on the Day state of the cause of a probably 4 were autopsy findings fror to completion of eath? Yes 2 No or (Specify) add	Year death Year death mber,
siclen: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	To Be Completed by Physiclan/Medical Ex	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of pregnancy 2 Fetal death at not resu	at enter the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the d	given in Part I. 26. Place of Decorate Cork? Yes 2 \(\) No se	23e. Did 1 1 24a. Wa autopent 1 1 Yes ath (Check only) tome 5 Res 28d. Describe	23d. Date More tobacco use contred? Yes 2 No 24b. V Pormed? one) idence 6 Other how injury occurred (Street and Number wm. State)	Approximatinterval Be Onset and William State of delivery on the Day state of the cause of a probably 4 were autopsy findings fror to completion of eath? Yes 2 No or (Specify) add	Year death Unknow a availate availate mber,
Physicien: The law requires that the death certificate be executed the second of the law requires that the certificate has been signed by the attending physician and injuries as the burial-transit.	Certification: To Be Completed by Physician/Medical Ex.	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Mannar of Death Natural S Pending investigated Pending Pendi	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of pregnancy 2 Fetal death at not resu	at enter the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the mode of decided and the d	given in Part I. 26. Place of Dead tork? Yes 2 No be a time, date and place of opinion, death occurs number	23e. Did 1 24a. Wa. autopen 1 Yes 28f. Location City or To. 28f. Location City or To. 3, and due to the gried at the time	23d. Date Mor tobacco use contr Yes 2 No s an 24b. V pormed? 2 No idence 6 Other how injury occurred www. State) cause(s) and man, date and place, a 29d. Date signed	Approximatinterval Be Onset and Conset (Specify) and Conset (Specify) and Conset (Specify) and Conset and Conset (Conset and Conset	Year death Gunkn avail cause
Physicien: The law requires that the death certificate be executed the second of the law requires that the certificate has been signed by the attending physician and injuries as the burial-transit.	Certification: To Be Completed by Physician/Medical Ex.	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Mannar of Death Natural S Pending investigated Pending Pendi	Due to (or as b. Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death a consequence of a consequence of pregnancy 2 Fetal death time of death a consequence of a consequence of pregnancy 2 Security 28b. Time of my knowledge, a consequence of	at enter the mode of decided and the control of the	given in Part I. 26. Place of Dead tork? Yes 2 No be a time, date and place of opinion, death occurs number	23e. Did 1 24a. Wa. autopen 1 Yes 28f. Location City or To. 28f. Location City or To. 3, and due to the gried at the time	23d. Date Mor tobacco use contr Yes 2 No s an 24b. V pormed? 2 No idence 6 Other how injury occurred www. State) cause(s) and man, date and place, a 29d. Date signed	Approximatinterval Be Onset and William State of delivery and be of delivery the Day state of the cause of all Probably 4 were autopsy findings from to completion of eath? Yes 2 No or (Specify) and or or Rural Route Number of Rural Rura	Year Year death avai cause

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Russell Rudolph Flynt 20, April 2005 а м /Medical 4:054a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1817 Reedie Drive Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2 ☐ F Months Director 577-64-2275 57 July 19, 1947 New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Directo Maryland 1 ☐ Yes 2 🔼 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1817 Reedie Drive Items 23a 20902 death Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 2 should be filed within 72 hours after a and Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Courier Courier Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McRusell Flynt Pages 1 and 2 should nent of Health and Mer 2 Armecia M. Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau Armecia M. Flynt/ Mother 1817 Reedie Drive, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 23, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Wensee 500 University Blvd, W, Silver Spring, MD 20901 23a. Part. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Pancreatic Cancer Months resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): anding physician and use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by pe page 2 should 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2□ No 1 Tyes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes & No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magney stated. 29a. Certifier Medical (Check only one) To the the 29b. Signature and title of ပ 29c. License number 29d. Date signed (Month, Day, Year) 2 MD 32864 April 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ari Daniel Fishman, M.D. 5530 Wisconsine Avenue, #1125, Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) APR 22 Registrar's Signature Registrar

	•	FOI	e of Marylan					21115	15456
Physicia	an						Month	Day Year	3. Time of Death
/Medic	December Name First, Models, Last Prancis Certificate of Death December Section December Dece	0:35							
- Autilii	٠.	Washington Adventist	Hospital					Mor	ntgomery
Physician //Medical Examiner Francis Xavier Fletcher 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital Funeral Director Funeral Director Funeral Director Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Day Year April 18, 2005 6:35 d 4c. County of Death Montgomery 7. Age (In yrs. last birthday) Months Day Year April 18, 2005 6:35 d 4c. County of Death Montgomery Funeral Director Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. Month, Day, Year Month, Day,									
D		Usual Residence of Decedent					May 22,	1920 1	
Aarylar F show	ъ								1 Tyes 2 No
r 28a-	Irect		.ge s n	yactsv			10	Og. Citizen of What Co	ountry?
ath with	TaiD								
036 urs after der al', or items	by Fune	1 Never Married 2 XMarried 1 X	ed Forces? Yes 2 ⊟ No				(Specify Yes or No- verto Rican, etc.)	Black, Whit	te, etc.
1215-00	mpleted	(Specify only highest grade comple	ege (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of			/Industry
land 2:	Be		2) Di	stributor	18. Mother's I			
The Registrate Proposition Pro		Zip Code)							
Physician Princis Xavier Pletcher April 18, 2005 6:35 6:35 7:40									
Pages ent of nt: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal	trom State	•		. 124	oril 27,		
Balti permit. Departm Importe any inju		21. Signature of uneral Service Lice, see	ny	2 F 5	rancis J. 00 Univer	ss of Facility Colling Sity B	ns Funeral	Home Inc.	
Medical Its be executed Its pe executed Its pe executed Its pe executed Its period and I	cai	shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mixtad events c	e on each line. PNE De to (or as a consequence of our account of our as a co	UMO uence of): NVE uence of).	NIA				Interval Batween Onset and Death 2 WE W
. 0 00	ysician/Me	23b. Was decedent pregnant in the past 12 months?	Live birth 2 ☐ Feta Pregnant at time of d	I death 3					*
rds, P. quires that I n signed by		Part II. Other significant conditions contributing	g to death but not res	ulting in the u	nderlying cause giv	en in Part I.			/
al Reco							autopsy perform	ned? death? ☐ No 1 ☐ Yes	
Vit	8	examiner?	1 Minpatient 2	ER/Outpatier	nt 3 DOA Oth	er			cify)
Division of a or attending Phy after death. Director: After thi din by the funeral din by		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injun Worl M 1	/ at k?	28d. Describe ho	w injury occurred	
Hospite t hours uneral		(Check only 2 Medical Examiner: On	the basis of examina	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the ca courred at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)
2+1 within to the comp	Me	29b. Signature and title of certifier Theory years	- MM						
	## 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?								
		APR 2 2 2005	Signar's Signa	K A	peaker				

State of Maryland / Department of Health and Mental Hygiene 005 For

2	Pos	1	-	
	J	14	U	

		•	= State Ragistrar			(Cert	ificate of l	Death		Reg. I	No.	10407
			1. Decedent's Name (First, Middle, Las	st)						2. Date of	Death		3. Time of Death
Phys /Ma	sicia: edica	_	GEN	E EDW	IN G	OCHENOU	R			MAY 3	. 20	Day Year	8:20 A.M
1	nine		4a. Facility Name (If not institution, give					4b. City, Town, or	Location of De			4c. County of Dea	th
			404 NORTH CHUR	CH ST				THURMON	тт.			FREDERIC	V
Fune	al		5. Social Security Number 6. S	өх		n yrs. last birth	day)	If Under 1 Year	If Under 24 H				thplace (State or Foreign ountry)
Direct			219-34-7324	X M 2□F		66 Y	rs.	Months Days	Hours M	n. (Month, AUG. 7	Day, Yea	8 EMM	ITSBURG, MI
ס			Usual Residence of Decedent							11000	,	9 12.2.2	12DORO, 11D
ylan			10a. State 10b. County		10	0c. City, Town	or Loca	ation					10d. Inside City Limits
Mar		פַ	MARYLAND FREDER	ICK	ļ		TH	URMONT					1 XYes 2 No
r 28g		Director	10e. Street and Number					10f. Zip Code			10g. (Citizen of What Co	ountry?
3a o	2	=	404 NORTH CHURCH	STREE	т			2178	8			U.S.A.	Ĺ
death		runeral	11. Marital Status	12. Was De	cedent Eve	er in U.S.	13. Wa			(Specify Yes or		14. Race - Ame	nican Indian
fter of the rest	i i	2	1 Never Married 2 Married		Forces? s 2X No			as Decedent of Hi Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)		Black, Whit	
O36 urs a	3	2	3 Widowed 4 Divorced	If Yes, 0 Year or	Give Dates:		1 [□Yes 2¥⊡No	Specify:			Specify: WH	ITE
5-0036 72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow olds Experiment of the property of the contract of the contr		Completed	15. Decedent's Ed	Jucation		16a. D	ecede	nt's Usual Occupa	ation		16b.	Kind of Business	Industry
	3	be	(Specify only highest gra		<u> </u>	(0	Give kii	nd of work done a NOT use retired	luring most of w	rorking			
2121; ed within 7 giene. er than "r		E	Elementary/Secondary (0-12)	College	(1-4or 5+)		LAB	ORER			C	ONSTRUCT	ION
filed Hygie	3		17. Father's Name (First, Middle, Last)						18. Mother's N	ame (First, Mid	dle, Maid	en Sumame)	
Maryland of 2 should be file th and Mental Hy 27 ie marked oth traumatic event	٥	0 00	CI VIDE VOER	ao a						TH SMIT		,	
Taryland 212 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Manalic event, the Manalic event, the Manalic event, the Manalic event the Manalic event, the Manalic event the	۲	-	CLAUDE ARTH 19a. Informant's Name/Relationship (1)		HENOU		Aailina	Aridrass (Street a				y or Town, State, 2	Zio Codel
					П								ip code)
Ore, N ges 1 and 3 t of Heelth If item 27 or other tr.		+	RUTH D. GOCHENO	JR/WIF.		20b. Place of D			H ST.,	Date		D. 21788 Location - City or	Town State
A 0 0			1 ☐ Burial 2X Cremation 3 ☐		m State			tory or other place					
ti Pg timer rtant		-	`4 □Donation 5 □ Other (Specify	<u> </u>		SMITHS		G CREMAT		/4/2005	SM	ITHSBURG,	, MD 21783
Baltimore, permit. Pages 1 ar Department of Hee important: If item any injury or other	once		21. Signature of Funeral Service Licen	see	./			Name and Addres				RAL HOME	
_ 40	<u> </u>	\dashv	John III.	Ma	les							MD. 217	27
			23a. Part 1. Enter the disease, or composition or heart failure. List only	olications that one cause on	t caused the reach line.	e death. Do no	t enter	the mode of dying	g, such as cardi	ac or respirator	y arrest,		Approximate Interval Between
Physicia	ın		Immediate Cause (Final disease or condition	. C+	PROIA	CAR	RH	YTH MI	4				Onset and Death
/Medic			resulting in death)	Due to	o (or as a c	onsequence of)):						1 /1//0 / 6
Examin			Sequentially list conditions,	bF	ULM	ONAR	4	HYPE	RTEN	SION			5YEARS
./ 🛭 =	- Cump	2	if any, leading to immediate cause. Enter Underlying	Due to	o (or as a co	onsequence of)	1.						
nd nd trans	8		Cause (Disease or injury that initiated events	c. C+	+RON	11C 0	35	TRUCTI	VE L	UNG- 1	215E	FASE	10 YEARS
O, e exe en a			resulting in death) Last	Due to	o (or as a co	onsequence of)	:						
octificate be executed certificate be executed ding physicien and se as the burial-transit	Modical	20	(d									
ப் திரு க	Pol	2	IF FEMALE:										
	1 5	_	23b. Was decedent pregnant	23c. If yes, o		regnancy Fetal death	3□E	ctopic pregnancy				23d. Date of deli	
death death se atter	3	2	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Preç	gnant at tim			other (specify)			_	Month	Day Year
Hecords, P.O. BG The law requires that the death tte has been signed by the atter page 2 should be detached for u	P A	riiysicia	9 🗆 Unknown	9□ Unk	nown								
S, F es tha gned be de	2		Part II. Dther significant conditions co	ontributing to	death but n	ot resulting in th	ne und	erlying cause give	n in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
COTO: w require been sig										11	Yes	2 □ No 3 □ Pro	obabiy 4 ∏Unknown
w requ	Completed	200								24a. W	as an	24b. Were au	topsy findings available
of Vital Record: Physician: The law require this certificate has been si	1		<u> </u>							au	topsy rformed?	prior to death?	completion of cause of
Vital F ician: Th certificate ector, pag	0		25. Was case referred to medical		-						2 🔯 N	lo 1 ☐ Yes	2 × No
of Vita Physician: this certificinal director,	α	ם	examiner?	Hospital:	7.1	α Π ΕΒ ίο :		3□ DOA Othe		eath (Check on			
Of Phys r this	F		27. Manner of Death	28a. Date		2 ER/Outpa		3 DUA	4 🗀 Nursing			6 Other (Spec	cify)
ding h. After funer	2	2	1 X Natural 5 ☐ Pending	(Mo	nth, Day Ye	ear) Inju		28c. Injury Work	? ′es 2 ∐ No	200. Describ	e now m	dry occurred	
in at in a	0	2	3 ☐ Suicide 6 ☐ Could not be		no of laium	At home for			63 2 1140	0.06	(0)		
DIVISION or Attending efter death. I Director: Afte	Cartification.		4 Homicide determined	build	ding, etc. (S	At home, farm Specify)	, street	t, ractory, office			Town, Sta	and Number or Ru ite)	fäl Houte Number,
pita urs eral			00 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1										
To the Hos within 24 ho To the Func completely f	legipa	2	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Madical Exam	inar: On the	ne best of m basis of exa	iy knowledge, c amination and/o	leath o	ccurred at the time stigation, in my op	e, date and plac inion, death occ	e, and due to the time	ne cause(e, date a	s) and manner as nd place, and due	stated. to the cause(s)
To the within 2 To the complet	Mad			and ma	nner stated	•							
7 Vit	-	-	29b. Signature and title of certifier	11		40		M D D 3			29d. D	ate signed (Month	, Day, Year)
			David S.	100	tre	سلايم ا		1000	0132		5,	/3/2005	
1			30. Name and address of person who o	ompleted car	use of death	(Item 23a) (Ty	pe, Pri	int) ():	1720	DAV	ID S.	. MOORE,	M.D.
<u> </u>			4910 H tairtiela	Kd	17	urheld	1	PH	17320				
	State		31. Date filed (Month, Day, Year) MAY 0 6 2	32.	gistrar's	Signature	- j	- A '5m					
Regi	strar		11/1 U 0 Z	005	du	K	400						
DHMH 17 Rev	1/200	1						7.72					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - 2<u>005</u> **Physician** Month Bertie Susie Collins Harris April 14, 1245 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton Caroline Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 3, 9. Birthplace (State or Foreign **Funeral** Months 213-22-5137 1 M 2 XF 87 Yrs. **19**18 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MD Caroline Denton **Funeral Director** 1▼ Yes 2 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21629 520 Kerr 238 Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married 9 Baftimore, Maryland 21215-0036 1 Yes 2X No White Specify. Be Completed by Specify: 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Canning Factories Laborer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If Itam 27 is marked other th any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Johnny Harvey Collins Mary Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19973 6017 Finchville/Reliance Rd., Seaford, DE William T. Collins/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery4/17/05 Federalsburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive veare /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, sician the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. м 1 □Yes 2 □No after death 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 detrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			1 - For State Registrar	State of I	Maryland	-	artment rtificate			ınd M		giene Reg. No.	005	15459
	Dhysisi	20	1. Decedent's Name (First, Middle, Last)			•					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Aristidis K. Hara	nis							April	20,	2005	4:18 P M
	Examir	ięr	4a. Facility Name (If not institution, give s		er)		,		Location of	f Death		4c.	County of De	ath
			Mercy Medical Cent 5. Social Security Number 6. Sex		Age (In yrs. Ia	na hinthulaul	Balt If Under	timo	re If Under 2	04 Hre	0. D. t (D)			
	Funeral Director			M 2□ E	77	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 12-15-	y, rear)		rthplace (State or Foreign Country)
-			Usual Residence of Decedent				LL				12-13-	-1921	GI	eece
	rylan show	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	86-1 s	cto	Maryland Anne Arur	ndel		Seven	1							1 ☐ Yes 2 ☐XNo
	with th	Dir	10e. Street and Number 1401 Graham Farm (Hwal a			10f. Zip					_	en of What C	Country?
	s 23g	eral		12. Was Decede	net Ever in 11 6	2 140.1		1144		:-0 /0	-7-17-1-11		eece	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurition of Health and Mental Ptygene. Depurtment of Health and Mental Ptygene. Important: If item 27 le marked other then "naturel", or Items 23c or 28e-1 show many njury or other traumatic event, if a Medical Extra ill art matter malified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ZNo	'	f Yes, spec 1 ☐ Yes 2	offy Cubar	Specify:	in/ (Spe Puerto f	cify Yes or No Rican, etc.)		Black, Wh	nencan Indian, ite, etc. White
9	"naturel",	ted	15. Decedent's Edu			16a. Dece	dent's Usua	l Occupa	tion			16b. Kir	d of Busines	s/Industry
218	within 7 ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	(Give life. I	kind of wor DO NOT us	k done di e retired)	uring most	of workir	ng			•
	filed wi Hygien ther th	S	5th			Fact	ory V	Vorke	er			Mac	hine S	hop
and Bud	be fill	Be	17. Father's Name (First, Middle, Last)						18. Mother		(First, Middle,		Surname)	
2	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, II a.M.	ပ္	Konstantinos 19a. Informant's Name/Relationship (Ty,		ramis	401 14 15		(0)			nstanti			nknown)
Maryland	d 2 sl th an 7 le r traur		Konstantinos A. Ha		Con						Route Numbe			
	of Health item 27 other tr		20a. Method of Disposition	цашь/	Son 20b. Pl	ace of Dispo emetery, crer	sition (Nam	lam E	arm (le, Sev			144 r Town, State
Baltimore,	permit, Pages Deportment of I Importent: If ite any njury or of		1 ☐ Burial 2 ☐ Cremation 3 💥R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	210	elawn elawn			_ 1	1-22-	05		•	ŕ
ij	permit. F Depurtm Importer any njui		21. Signa of Funeral Sevice License	90	1 111				-				watosa as Fun	eral Home
ä	Dep Impo		1 Went of alle			2	2973 5	Solon	ons 1	Islar	nd Rd.	Edge	water,	MD 21037
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on eac	sed the death. h line.	LA/S	Hoc		, such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner	L	Sequentially list conditions, b	me	la bo	IC	No	rde	5715					Unknown
o,	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	chr	as a consequence as a consequence	12	PIF	MI	ry 1	FAI	lope	_		6 months
68760,	ate be nysicia he bu	edlcal												
O. Box 68	attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal of de	death 3□	Ectopic pre					2	3d. Date of de Month	olivery Day Year
٦.	res that the digned by the be detached	y Ph	Part II. Other significant conditions con	tributing to deat	h but not resul	lting in the ur	nderlying ca	use give	n in Part I.	****	23e. Did to	bacco us	e contribute t	to the cause of death?
rds,	quires in sign uld be	ed by									1,24	′es 2□]No 3 □ P	robably 4 Unknown
Record	aw requin as been si 2 should I	Completed									24a. Was		24b. Were a	utopsy findings available
Ä	The law te has bage 2	mo										sy med? 2 No	death?	completion of cause of s 2 \sum No
Vital	ysiclen: The is certificate hidirector, page	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		10,76	20110
of V		To	1 Yes 2 No	ospital: 1 np	atient 2□E	R/Outpatien	t 3□ DO	A Other	r: 4 □ Nur:	sing Horr	ne 5 ☐ Resid	lence 6	□Other (Spe	ecify)
Division o	ding After fune	Certification;	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of J (Month,	njury Day Year)	28b. Time of Injury	M 28	3c. Injury Work 1	at ? es 2 □ N		8d. Describe h	ow injury	occurred	
Divi	in Pite		4 Homicide determined	building,	Injury - At hon, , etc. <i>(Specify)</i>	}					City or Tow	m, State)		lural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	dedical	29a. Certifier (Check only one) Certifying Physical Examination	ician: To the be er: On the basis and manner	s of examinati	riedge, death on and/or inv	estigation,	in my opi	inion, death	place, a occurre	d at the time, o	date and p	olace, and du	e to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier					License	27	P		1	٥.	th, Day, Year)
								77 (136		8	1000	1150	1005
			30. Name and address of person who co	A . 1 .	of death (Item	23a) (Type,	Print)	12	00	1011-	ZMJ	1 -	- nn	1
	Sta	to.	31. Date filed (Month, Day, Year)	XICUN 32. Pg	istrar's Signatu	ure / 5	PH	UCI	16	TIL	CAN O	E	Con K	1 41 405
d	Registr		APR 2 1 26			K A	Trail of	San San San San San San San San San San	D400000-0-1					

			1 - For State Registrar	State of Maryland /		artment tificate			nd Me		giene	2005	151.60
	Physicia		Decedent's Name (First, Middle, Last) JACK WILSON JOY							2. Date of Dea Month APRIL	Day	Year 2005	3. Time of Death 9:25 P M
Ł	/Medic Examin		4a. Facility Name (If not institution, give single FREDERICK MEMORIAI			4b. City,		Location of	_	2 (10 2)	4c. (County of Death	h
	Funeral Director			7. Age (In yrs. last bi	rthday) Yrs.	If Under Months		If Under 24 Hours	4 Hrs. 8 Min.	B. Date of Birtl (Month, Da) 6-27		9. Birth	hplace (State or Foreign untry) aryland
7	f show	or	Usual Residence of Decedent 10a. State 10b. County Freder:	ick 10c. City, Tow	wn or Lo	cation ick							10d. Inside City Limits 1▼ Yes 2 □ No
di di	3a or 28a-	i Director	10e. Street and Number 412 Grant Place			10f. Zip	Code 1702				_	en of What Co	untry?
d 21215-0036	Javinin 72 flous area destravior fre maryar, jiene. Then "natural", or llema 23a or 28a-f show. The Modical Examilier chast be notified at	by Funeral	11. Marital Status t Never Married 2 XMarried 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 NWII If Yes, Give Year or Dates:	i	Was Deced f Yes, spec	Х	spanic Origin , Mexican, I Specify:	in? (Speci Puerto Ri	ify Yes or No- ican, etc.)		4. Race - Ame Black, White Wh Specify:	rican Indian, e, etc. ite
21215-0036	I Hygiene. other than "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) I2th	cation 16a completed) College (1-4or 5+)	Deced (Give life. L	lent's Usua kind of wor DO NOT us sable	l Occupa k done d e retired) d Am	tion during most of lerical	of working n Vet	teran	16b. Kin	of Business/I	Industry
Maryland	ental kad c	To Be C	17. Father's Name (First, Middle, Last) John Joy							First, Middle, ine Dav		Surname)	
	tra		19a. Informant's Name/Relationship (Type Lillian Thomas Jo							Route Numbe rick, N		Town, State, 2 21702	Tip Code)
9			20a. Method of Disposition 1 Burial 2 Tremation 3 Re 4 Donation 5 Other (Specify)	emoval from State 20b. Place of Smiths	of Dispo Pry, cren B DUT	sition (Nam natory or of g Cre	ne of ther place mato	ry 4.	-22 - 2	te 2005		thsburg	
Balt	Definit. Page Department of Important: If any injury or QDCE.		21. Signature of Pureral Service License	Julet !	R 0 12	BERT ^{and}	E ^{Addr} D Mark	ATTEY et St	& S0	ON FUNI edericl	ERAL k, Mo	HOMES,	P.A.
	nysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only enter the disease or condition resulting in death)	EMPH95E	44		e of dying	g, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death YEARS
	xaminer	er	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequence									
8760,	ate be executed hystolan and the burial-transit	icai Examiner	cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a consequence	of):								
. Box 6	e attending pod for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal deatt 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pro					2	3d. Date of deli Month	ivery Day Year
rds, P.	ine law requires mat me ite has been signed by th page 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not resulting	in the ur	nderlying ca	ause give	in in Part I.					the cause of death?
al Records,		Completed							_	24a. Was autop perfor 1 Yes	sv /	24b. Were au prior to death?	topsy findings available completion of cause of 2 No
t Vite	this certifical director	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	ospital: 1 Inpatient 2 ☐ ER/O	utpatien	t 3□ DO	A Othe			<i>Check only o</i> e 5 ☐ Resid		Other (Spec	city)
Division of Vital	After fune		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	M 2	8c. Injury Work 1 🗆 Y	at ? ∕es 2 ∐ No		d. Describe h	now injury	occurred	
Divis	o ir de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)					1	City or Tow	vn, State)		ral Route Number,
	within 24 hours a To the Funeral C completely filled in	edical	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	je, death nd/or inv	occurred a vestigation,	at the tim in my op	e, date and inion, death	place, an occurred	d due to the of at the time, of	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	withir To th	Ň	29b. Signature and title of certifie	in.	MI			number 499	7			signed (Month	
	3		30. Name and address of person who con Ronald E. Miller,				. Ai	ry. Ma	arvla	and 217	771		
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 5 20	32. egistrar's Signatur		201	F						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	For State Registrar		Cei	tificate of L	Death		leg. No.	1046
Physician /Medical	Decedent's Name (First, Middle, Last Frederick)	Jones			2. Date of Dea Month	Day Year	3. Time of Death
Examiner	4a. Facility Name (If not institution, give	street and number)	Зопев	4b. City, Town, or	Location of Death	APLIL	4c. County of Dea	8:25 p
Ladimie	Montgomery Genera			01n			Want	
Funeral	5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgo 9. Bir	thplace (State or Fore
Director	332 44 1500 Usual Residence of Decedent	M 2□F 55	Yrs.	Months Days	Hours Min.	Sept 4;	r, Year) Co	ountry) 11inois
aryland show	10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Lim
28e-f	Maryland Montgon 10e. Street and Number	ery	01ney	10f. Zip Code	<u>-</u>		log. Citizen of Whal Co	1 Tyes 2 X
23a or	3801 Mount Olney I	ane		208	32		USA	outiny :
be filed within 72 hours after death with the Maryland and Hylgiene. d other than "neturel", or items 23a or 28e-f show event, the Madical Examinar must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give	ĺ	Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2 hours a seturel, o ical Example ted by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16a. Deced	lent's Usual Occupa	tion	1	16b. Kind of Business	1/4
ed within 72 ho ygjene. ner than "netur. t, It e M. sical Completed	(Specify only highest grad	e completed) College (1-4or 5+)	life. L	kind of work done di DO NOT use retired) ial Worke				
illed v I Hygie other t ent, Ib	17. Father's Name (First, Middle, Last)	4	500				ity of New Maiden Sumame)	York
should be a marked o umatic eve	Frederick Jones				Mary C			
d 2 g	19a. Informant's Name/Relationship (T) Mary Jones / Wife	pe, Print)					, City or Town, State, 2	
of Heal	20a. Method of Disposition		b. Place of Dispo	sition (Name of natory or other place			laryland 20 20c. Location - City or	
Part in A	1 Burial 2 Cremation 3 F	F	t Lincol	n Cremato	rv 4/26	5/2005	Brentwood,	Maryland
perrit. Pag Dep-riment Important: any injury o	21. Signature of Funeral device Licens	Elison		. Name and Address 1800 New 1	of Facility Hine	s Rinal	di Funeral lver Sprin	Home 2090
	23a Part 1. Enter the disease, or complete the complete complete the complete comple	ications that caused the cone cause on each line.	death. Do not ente	er the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Pnysician /Medical	Immediate Cause (Final disease or condition resulting in death)	aAvrhy-	hmle					Minu HS
Examiner	Sequentially list conditions,	Hyper	ensico)				Years
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events	Perione	sequence of):	asula	Dice	050		Years
	resulting in death) Last	Due to (or as a con-	sequence of):	0 50011.00	0.20			1
ntificate being physicia as the bu		i						
attendin for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Date of deli	ivery Day Year
nat the death or d by the attend letached for us	1 Yes 2 No 9 Unknown	4□Pregnant at time o	of death 5	Other (specify)			Worth	Day real
igne be d	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	derlying cause giver	n in Part I.		pacco use contribute to	
The taw requir te has been si age 2 should ompleted						24a. Was a		obably 4. Onknow
cate has page 2	ļ					autops perforn	y prior to d	topsy findings availat completion of cause of 2 \sumble No
certific rector,	25. Was case referred to medical examiner?	la aniha t			26. Place of Death		•	
ng Phys fter this ineral di	1 Yes 2 No Canal Yes	lospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatient 28b. Time of Injury	28c. Injury : Work?	4 Nursing Ho		ence 6 Other (Spec ow injury occurred	cify)
teat for: the the	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A	At home, farm, stre		es 2 No		reet and Number or Ru	ral Route Number,
urs afte	4 - Homicide	building, etc. (Spe				City or Town		
To the Hospitel or Alwithin 24 hours after of to the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurr	and due to the ca ed at the time, da	luse(s) and manner as ate and place, and due	stated. to the cause(s)
To the within 2 To the complet	29b. Signature and tife of certifier			29c. License	number	29	9d. Date signed (Month	i, Day, Year)
5	30. Name and address of person who co	_ M.D.	itom 22a\ /T	d 60	777	\times	tpril 18	, 2005
	18101 Prince Philip	porte 01	Ney . W	ayland.	26832	Kerri	Armon	M.O
State	31. Date filed (Month, Day, Year) APR 2 2 20	32 Registrar's Si	gnature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death . UU 3. Time of Death Day 2005 Physician Month Year April 19, Ruth Lee Kummell 6:05AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 3, 9. Birthplace (State or Foreign 1 ☐ M 2 🕱 F Yrs. Maryland Director 82 217-14-2193 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits in than "naturat", or Itams 23a or 28a-f ahow The Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Maryland Howard Ellicott City 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 8720 Ridge Road #314 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White 3 ☐ Widowed 4 🛣 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Pages 1 and 2 should be filed annent of Health and Mental Hygic int; If itam 27 Is marked other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Nelson Fisher Frances Ellsworth Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 l Karen K. Rock/daughter 1521 Humbert Schoolhouse Rd. Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 21, Department of H Important: If its any injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory ^ 4 □ Donation 5 □ Other (Specify) 2005 Odenton, Maryland Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Jancreatic cancer with disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year 4 Pregnant at time of death Month Day 5 Other (specify) be detached δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: 1 Yes 20 No 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSP (Ce 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attanding Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours at To tha Funaral C completely filled i 29a. Certifler Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), ospice 838 Entaw State

Registrar

ROBINI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** MATLYA APRIL 17, 9:50 AM KHASDAN /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 80 yrs. Birthplece (State or Foreign Country)
 RUSSIA **Funeral** 1□M 2XF 213-21-8450 1925 Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at MD 1X Yes 2 No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 14411 TRAVILLE GARDEN CIRCLE, APT. 401 20850 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY GOVERNMENT permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NACHUM KATZNELSON or other treumatic NECHA ZUKERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NELLA ROZOFSKY/DAUGHTER 13617 VALLY OAK CIRCLE, ROCKVILLE, MD 20852 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State JUDEAN MEMORIAL GARDENS 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 04/20/2005 * 4 ☐ Donation 5 ☐ Other (Specify) OLNEY, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. Donald (rottlemer 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Pert1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final Metastatic Physician disease or condition /Medical resulting in death) Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed?

1 Yes 2 No certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) : Alter this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 55258 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hackville Many B wilks MD Montrop 1610 31. Date filed (Month, Day, Year) Registrar's Signature State 2 2 2005 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. UU Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year Physician Lehman Agnes 11:15 P. M Apri1 26 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mennonite Old People's Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 X F Penna. Yrs 204-30-5104 67 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23e or 28e-f show the Medical Exercitive thus be notified at 1 ☐ Yes 2 X No MD. Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13436 Maugansville Rd. 21740 U.S.A. death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status of filed within 72 hours after of Hygiene. In Hygiene. other then "naturel", or Iter 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 💢 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Printing Co. 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other eny injury or other treumetic event size. 17. Father's Name (First, Middle, Last) Be Mary Catherine Oberholzer Amos F. Lehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathan Diller /Executor 21619 Chewsville Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State Millers Mennonite Church Cemetery 4/30/05 Leitersburg, Md. • 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zimmerman And Son Funeral Home 21. Signature of Funeral Service Licensee 45 S. Carlisle St. Greencastle, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Artes Priysician Codina /Medical Due to (or as a consequence of): Examiner OFBNARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner and Il-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Physician/Medical as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 KINO the 9□ Unknown 9 Unknown ፭ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 1 ☐ Yes 2 DINO 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has 2 No certificate 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 11💆 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the

State Registrar 29b. Signature and title of certifie

31. Date filed (Mooth, Day, Year)

Steven L. Hatleberg, Md. 11110 Medical Campus Rd. Suite 150 Hagerstown, Md. 21742 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baitimore, Maryland 21215-0036

Box 68760,

o

Records, P.

Division of Vital

29d. Date signed (Month, Day, Year)

27

ZOOS

Please Type or Print in Black Indelible lpk. Ensure All Copies Are Legible. Amend item 10b per fh 8843 5-11-05 vt

			Ter State Registrar		artment of Health and I rtificate of Death	Mental Hygie Reg.	0000				
			Decedent's Name (First, Middle, Last)			2. Date of Death	3 Time of Death				
	Physic /Medi		Peter	Loomis			Day Year 6 25AM				
	Exami		4a. Facility Name (If not institution, give street and	d number)	4b. City, Town, or Location of Death	140					
			Shady Grove Adventist	Hospital	Rockville		Montgomery				
	Funeral		5. Social Security Number 6. Sex 1 → M 2 □	7. Age (In yrs. last birthday) F 79 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9 Rirthplace (State or Foreign				
	Director		Usual Residence of Decedent	79 115.		Dec. 15,	1925 Washington, D.				
	/land		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits				
	Many First	tor	Maryland Worcester	Ocean Pir	ies		1 ☐ Yes 2 No				
	r 28g	irec	10e. Street and Number	·	10f. Zip Code	10g.	Citizen of What Country?				
	th wit	aiD	15 Essex Court		21811		USA				
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show amortant: If item 27 is marked other than "neturel", or Items 23a or 28a-f show injury or other traumatic event, I're Medical Examiner must be notlined at once.	d by Funeral Director	11. Marital Status 12. Was Arme 1	'es 2 □ No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert I □ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
21215-0036	vithin 72 h ne. han "netu e Medical	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	ted) 16a. Dece (Give life. L	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b	. Kind of Business/Industry				
22	iled v lygie ther t	ပိ	17. Father's Name (First, Middle, Last)	2	Owner	ne (First, Middle, Maid	owling Center				
Maryland	t be f ntal h ed of	Be									
Ž	hould d Me mark matic	To	William Loomis 19a. Informant's Name/Relationship (Type, Print,	19h Mailin	Evangel:	ia Sarela					
S	id 2 s ith an 17 is trau		Christine S. Loomis /		ssex Court Ocean						
ē,	Heal Heal tem 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		yland 21811 Location - City or Town, State				
Baltimore,	ages ant of tr: # if		1 X Burial 2 ☐ Cremation 3 ☐ Removal f '4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) leaven Cemetery 4		lver Spring, Marylan				
量	ortan injur		21. Signature of Funeral Service Licensee		. Name and Address of Facility H1 1						
Ba	Depril Impo		Town New	Jan - 11	800 New Hampshire	e Ave Silv	er Spring, MD 20904				
	Physician		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	hat caused the death. Do not ente on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between				
			Immediate Cause (Final disease or condition	Sepsis			Onset and Death				
	/Medical Examiner		resulting in death)	e to (or as a consequence of):							
		٠.	Sequentially list conditions, b.								
		nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
_	ificate be executed 3 physician and as the burial-transit	xan	that initiated events c								
68760,	be e sician buria	aiE		1							
387	ficate phys s the	edicai	d								
	attending for use a			, outcome of pregnancy			23d. Date of delivery				
. Box		Physician/M	in the past 12 months?	regnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year				
P.0	at the d by the tached	hys	9 □ Unknown 9□ U	Inknown							
	w requires that s been signed b should be det		Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?				
ord	equire en si ould (ted	Cardio my opathy			1 🗆 Yes	2 No 3 Probably 4 Unknown				
of Vital Records,	lawr as be 2 sh	Completed by				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
<u>m</u>		М				performed	death?				
/ita	ticien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)					
× ×	Physic this co	2	1 ☐ Yes 2 ☐ No Hospital:	1 Inpatient 2 ER/Outpatien		ome 5 Residence	6 □Other (Specify)				
ū	ding Physicien: h. After this certific funeral director,	on:	27. Manner of Death 1.✓Natural 5 □ Pending	Date of Injury 28b. Time of Month, Day Year) Injury	28c. Injury at Work?	28d. Describe how in	ijury occurred				
Sic	tend leath tor: /	cat	2 Accident investigation M 1 Yes 2 No 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number of the country of the								
Division	f or Attendi after death. Director: A in by the fu	Certification:	determined 286. P	lace of Injury - At home, farm, stre uilding, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)				
	pitel		29a. Certifier 1/ Certifying Physician: To	the best of my knowledge death	Consumed at the first data and the		/-\				
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	(Check only 2 Medical Exeminer: On the	o the best of my knowledge, death he basis of examination and/or inv manner stated.	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)				
	o the	Me	29b. Signature and title of certifier	111	29c. License number	29d. I	Date signed (Month, Day, Year)				
	/		I Christie lepo	nte MD	61549	~	pri/20 2005				
	5		30. Name and address of person who completed		Print)	10 92					
			Christine Le	DOUTE 9901 M	ledical Center Dri	ve Rockvi	lle, Maryland 20850				
	Sta	ate	31. Date filed (Month, Day, Year)	. Registrar's Signature	M .		, , , , , , , , , , , , , , , , , , , ,				
	Regist		APR 2 2 2005	The GOBA							

		State Amend Registrar 1. Decedent's Name (Fir					707177041				2. Date of D				2 Time of Deed
siciar	_			,							Month April	Day 29		Year O E	3. Time of Death 2:55p
edica		Robert Otto Miedl 4a. Facility Name (If not institution, give street and number)					4b. City.	4b. City, Town, or Location of Death				-	29 2005 2: 4c. County of Death		2.33p
minei	١	12300 Green	_		•			ensb					Caroline		
ral	Ę	5. Social Security Number		Sex	7. Age (In	yrs. last birth	day) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi				lace (State or Foreig
tor		210-12-0170	0	1 X M 2□F	78	Yr	S. MONUIS	Days	Hours	IVIII I.	Dec. 2	1 1926	5]	Penn	sylvania
	- 1		o. County		10	c. City, Town	or Location							1	0d. Inside City Limit
Re Completed by Fitneral Director		Maryland Ca	arolin	e		Green	sboro								1 X Yes 2 □ N
Directo	Le	10e. Street and Number					10f. Zip	10f. Zip Code					en of Wh	at Coun	try?
		12300 Green	nsboro	Road				2163	39			U.S.A	Α		
Firmeral	nue	11. Marital Status	**	Armed F	cedent Ever Forces?	r in U.S.	Was Deceded if Yes, specific	dent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or N Rican, etc.)	0- 14		- Americ White,	an indian, etc.
<u> </u>	Dy L	1 Never Married 3 Widowed 4		1 X Yes	s 2 □ No Give 19	43-50	1 🗆 Yes	2 🗓 No	Specify:			S	Specify:	Wh	ite
7		15.	Decedent's E	ducation		16a. D	ecedent's Usua	ai Occupa	ation			16b. Kind	d of Busi	iness/Inc	dustry
100	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				- 6	Give kind of wo ife. DO NOT u	rk done d se retired,	t of work	ing		,			
1	é _					dep	artment manager					reta	retail store		
	De	17. Father's Name (First, Middle, Last)							18. Mothe	r's Nam	e (First, Middle	e, Maiden S	aiden Sumame)		
	0	Otto Miedl							Anna	Mar	ie Sch	raff			
		19a. Informant's Name/F	Relationship	(Type, Print)		19b. N	Mailing Address	(Street a	and Numbe	er or Run	al Route Numb	er, City or	Town, St	tate, Zip	Code)
		Rita Mae M					300 Gre								
	1	20a. Method of Disposition 1 ↑ Burial 2 □ Cre		□Removal from	III State		isposition (Nar crematory or c				Date	20c. Loca	ation - Ci	ity or To	wn, State
once.		`4 □Donation 5 □	Other (Speci	fy)	E	Eastern	Shore	Vet	Cem 1	May	3 2005	Hurl	ock,	, Ma	ryland
9		21. Signature of Fymeral	I Service Lice	nsee	,		Fleegle PO Box	nd Addres	s of Facilit	fenb	ein Fu	neral	Home	e. P	'A
a		1 kin		e	-ul		DO ROY	160	Gree	nsbo	ro, MD	21639)		
		shock, or heart failure. List only one cause on each line.													
		shock, or heart fail	lure. List only	one cause on	n each line.		t enter the mod								Approximate Interval Between
_		shock, or heart fail Immediate Cause (Final disease or condition	lure. List only	one cause on	n each line.	FAIL	t enter the mod								Approximate
		shock, or heart fail Immediate Cause (Final	lure. List only	a. RE	n each line.	FAIL (t enter the mod								Approximate Interval Between Onset and Death
	a	shock, or heart fail Immediate Cause (Final disease or condition resulting in death)	lure. List only	a. Re Due to Dia	o (or as a co	FAIL	t enter the mod								Approximate Interval Between Onset and Death
	miner	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediates. Errer Underlying Cause (Disease or Injury)	lure. List only	a. Re Due to Dia	o (or as a co	FAIL (t enter the mod								Approximate Interval Between Onset and Death
	cxaminer	shock, or heart fail Immediate Cause (Final disease or condition resulting in death)	lure. List only	a. Report to Due Due Due Due Due Due Due Due Due Due	n each line. NAC o (or as a co lbetes o (or as a co	FAIL (enter the mod								Approximate Interval Between Onset and Death
Fyaminer		shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list conditio if any, leading to immed cause. Einer Underlying Cause (Disease or injury that initiated events	lure. List only	a. Report to Due Due Due Due Due Due Due Due Due Due	n each line. NAC o (or as a co lbetes o (or as a co	FAIL (onsequence of) Mellit onsequence of)	enter the mod								Approximate Interval Between Onset and Death
cai Evaminer	Ca	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition fany, leading to immediate. The underlying Cause Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	lure. List only	a. Report to Due Due Due Due Due Due Due Due Due Due	n each line. NAC o (or as a co lbetes o (or as a co	FAIL (onsequence of) Mellit onsequence of)	enter the mod								Approximate Interval Between Onset and Death
r L L	Ca	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition fany, leading to immediate. Enter Unidentification Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg	ons, diate	b. Due to	o (or as a co local accordance of poutcome of p	FAIL (consequence of Mellit onsequence of mesequence of me	t enter the mod	de of dying				arrest,	d. Date o	of delive	Approximate Interval Between Onset and Death
cai Evaminer	Ca	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list conditio if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 \(\text{Yes} \) 2 \(\text{No} \)	gnant ths?	b. Due to	o (or as a co o (or as a co o (or as a co o (or as a co o (or as a co o utcome of p a birth 2 gnant at time	FAIL (insequence of Mellit insequence of inseque	enter the mod	de of dying				arrest,		of delive	Approximate Interval Between Onset and Death
cai Evaminer	nysician/medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list conditio if any, leading to immed cause. Emer Underlying Cause (Disease or injur) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	gnant	b. Due to Due Due to Due to Due Due Due Due Due Due Due Due Due Due	o (or as a co location of particular or or as a co o (or as a co o (or as a co o utcome of particular or	FAIL Consequence of Mellit insequence of mesequence of mes	t enter the mod	regnancy	g, such as	cardiac	or respiratory a	arrest,	id. Date o Month	of delive	Approximate Interval Between Onset and Death D
hy Dhysiclan/Modical Evaminer	by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list conditio if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 \(\text{Yes} \) 2 \(\text{No} \)	gnant	b. Due to Due Due to Due to Due Due Due Due Due Due Due Due Due Due	o (or as a co location of particular or control of particular or control or c	FAIL Consequence of Mellit insequence of mesequence of mes	t enter the mod	regnancy	g, such as	cardiac	23e. Did	23	ld. Date o Month	of delive	Approximate Interval Between Onset and Death Year Pay Day Year e cause of death?
hy Dhysiclan/Madical Evaminar	by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list conditio if any, leading to immed cause. Emer Underlying Cause (Disease or injur) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	gnant	b. Due to Due Due to Due to Due Due Due Due Due Due Due Due Due Due	o (or as a co location of particular or control of particular or control or c	FAIL Consequence of Mellit insequence of mesequence of mes	t enter the mod	regnancy	g, such as	cardiac	23e. Did	arrest,	ld. Date o Month	of delive	Approximate Interval Between Onset and Death Year Pay Day Year e cause of death?
hy Dhysician/Medical Examiner	by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list conditio if any, leading to immed cause. Emer Underlying Cause (Disease or injur) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	gnant	b. Due to Due Due to Due to Due Due Due Due Due Due Due Due Due Due	o (or as a co location of particular or control of particular or control or c	FAIL Consequence of Mellit insequence of mesequence of mes	t enter the mod	regnancy	g, such as	cardiac	23e. Did	23 tobacco use Yes 2 san	id. Date of Month	of delive	Approximate Interval Between Onset and Death Death Onset and Death Death Onset and Death Death Death Death Dea
hy Dhysiclan/Modical Evaminer	Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list conditio if any, leading to immed cause. Emer Underlying Cause (Disease or injur) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	gnant	b. Due to Due Due to Due to Due to Due to Due Due Due Due Due Due Due Due Due Due	o (or as a co location of particular or control of particular or control or c	FAIL Consequence of Mellit insequence of mesequence of mes	t enter the mod	regnancy	g, such as	cardiac	23e. Did	23 tobacco use Yes 2	dd. Date of Month of Contribution No. 3 24b. We price	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Interval Between Onset Indiana Onset
Be Completed by Dhysician/Madical Examiner	Be completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregint he past 12 month of the past 12 month of the past 12 month of the past 13 month of the past 14 month of the past 15 month of the past 16 month of the past 17 month of the past 18 month of the past 19 mont	gnant ths?	b. Due to d. 23c. If yes, o 1 Live 4 Pres 9 Unk	o (or as a co o (or as a co o (or as a co o (or as a co o to (or as a co o do (or as a co o do (or as a co o do (or as a co o	regnancy Fetal death of death of resulting in t	t enter the mod	regnancy pecify)	g, such as	cardiac	23e. Did 1 24a. Wa: auto per 1 Yes h (Check only to the control of the cont	tobacco use Yes 2 s an oney one)	dd. Date of Month of Contribution No. 3 24b. We price	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Interval Death Onset Indiangual Onset Indiangua
To Be Completed by Dhysician/Medical Examiner	to be completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregint he past 12 month of the past 12 month of the past 12 month of the past 13 month of the past 14 month of the past 15 month of the past 16 month of the past 17 month of the past 18 month of the past 18 month of the past 19 month of the past 19 month of the past 11 month of the past 11 month of the past 11 month of the past 12 mont	gnant ths?	Due to Due to Dia b. Due to Due to Dia b. Due to	o (or as a co o (or as a co o (or as a co o (or as a co o (or as a co o do (or as a co o (or as a co o (or as a co o do (or as a co o (or as a	regnancy Fetal death of death of resulting in t	tenter the mod	regnancy pecify)	g, such as an in Part I. 26. Place	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only) me 5 1 es	tobacco use Yes 2 s an posy orned? 2 No one) idence 6	dd. Date o Month e contrib No 3 24b. We pricedes 1 [of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death
To Be Completed by Dhysiclan/Medical Evaminer	to be completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown Part II. Other significant 25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5	gnant ths?	b. Due to c. Due to d. 23c. If yes, o 1 Live 4 Pre; 9 Unk contributing to	o (or as a co o (or as a co o (or as a co o (or as a co o to (or as a co o do (or as a co o do (or as a co o do (or as a co o	regnancy Fetal death of resulting in t	tenter the mod	regnancy pecify) ause give	g, such as an in Part I. 26. Place ar: 4 □ Nu	cardiac	23e. Did 1 24a. Wa: auto per 1 Yes h (Check only to the control of the cont	tobacco use Yes 2 s an posy orned? 2 No one) idence 6	dd. Date o Month e contrib No 3 24b. We pricedes 1 [of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death O
To Be Completed by Dhysician/Medical	to be completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 month 1	gnant the conditions o medical	b. Due to Dia b. Due to d.	o (or as a co o	regnancy Fetal death of tresulting in t	tenter the mod	regnancy pecify) Cause give	g, such as on in Part I. 26. Place ar: 4 □ Nu	cardiac	23e. Did 1 24a. Waraute 1 Yes h (Check only me 5 See 28d. Describe	tobacco use Yes 2 s an psy ormed? 22 No one) idence 6 how injury	dd. Date of Month e contrib No 3 24b. We price dead of the contribution of the cont	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Indianal Onset Indiana Onset Indi
To Be Completed by Dhysician/Medical Examiner	to be completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 month 1 Yes 2 No 9 Unknown Part II. Other significant 25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Yes 2 No 27. Manner of Death 1 Yes 2 No 28. Manner of Death 1 Notice o	gnant ths? It conditions O medical	Due to Du	o (or as a co o	regnancy Fetal death of death of resulting in t	tenter the mod	regnancy pecify) Cause give	g, such as an in Part I. 26. Place ar: 4 □ Nu	cardiac	23e. Did 1 24a. Was autopert 1 Yes h (Check only me 5 X es 28d. Describe	tobacco use Yes 2 s an psy ormed? 22 No one) idence 6 how injury	dd. Date of Month e contrib No 3 24b. We price dead of the contribution of the cont	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death O
Cartification: To Be Completed by Dhysician/Madical Examiner	Certification: 10 be completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 montion of the past 12 montion of the past 12 montion of the past 12 montion of the past 13 montion of the past 14 montion of the past 15 montion of the p	gnant ths? t conditions o medical Pending investigatic Could not t determined	Due to Due to Dia b. Due to Di	o (or as a co o	regnancy regnancy regnancy regnancy resulting in t	t enter the mod	regnancy pecify) DA Other Page 1 Injury Virth 1	g, such as 26. Place 37. 4 □ Nu 31. 4. Yes 42. Yes 2 □	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only me 5 Ses 28d. Describe	tobacco use Yes 2 s an one) idence 6 how injury (Street and wn, State)	dd. Date of Month e contribute 24b. We pring dea 1 Other occurred Number	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Interval Between Onset Interv
Cartification: To Be Completed by Divisic lan/Madical Evaminer	Certification: 10 be completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 month of the past 12 month of the past 12 month of the past 12 month of the past 12 month of the past 12 month of the past 12 month of the past 13 month of the past 14 month of the past 15 month of the past 15 month of the past 15 month of the past 15 month of the past 15 month of the past 15 month of the past 15 month of the past 15 month of the past 15 month of the past 15 month of the past 15 month of the past 12 month of the past 15 month of the past	gnant ths? gnant ths? t conditions o medical Pending investigatic Could not to determined Certifying P.	Due to Dia b. Due to Dia b. Due to Dia b. Due to d. Due	o (or as a co o	regnancy regnancy regnancy regnancy resulting in t	t enter the mod	regnancy pecify) DA Other Page 1 Injury Virth 1	g, such as 26. Place 37. 4 □ Nu 31. 4. Yes 42. Yes 2 □	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only me 5 Ses 28d. Describe	tobacco use Yes 2 s an one) idence 6 how injury (Street and wn, State)	dd. Date of Month e contribute 24b. We pring dea 1 Other occurred Number	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death
Cartification: To Be Completed by Dhysician/Madical Examiner	legical Certification: 10 Be Completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregint the past 12 month of the past 12	gnant ths? It conditions o medical Pending investigation Could not the determined Certifying P. Medical Exa	Due to Dia b. Due to Dia b. Due to Dia b. Due to d. Due	o (or as a co location of particles o (or as a co o (or as	regnancy regnancy regnancy regnancy resulting in t	t enter the mod	regnancy pecify) DA Other Cause give Vicinity of the Vicinity	g, such as 26. Place 37. 4 □ Nu 31. 4. Yes 42. Yes 2 □	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only me 5 Ses 28d. Describe	tobacco use Yes 2 s an one) idence 6 how injury (Street and wn, State)	dd. Date of Month e contribute 24b. We pring dea 1 Other occurred Number	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death O
Cartification: To Be Completed by Dhysician/Madical Examiner	legical Certification: 10 Be Completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition if any, leading to immediate Sequentially list condition if any, leading to immediate Sequentially list can be sequentially listed to immediate Sequentially listed to immediate Sequential Sequent	gnant ths? It conditions o medical Pending investigation Could not the determined Certifying P. Medical Exa	Due to Dia b. Due to Dia b. Due to Dia b. Due to d. Due	o (or as a co location of particles o (or as a co o (or as	regnancy regnancy regnancy regnancy resulting in t	t enter the mod	regnancy pecify) DA Other Cause give Vicinity of the Vicinity	g, such as 26. Place 37. 4 □ Nu 31. 4. Yes 42. Yes 2 □	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only me 5 Ses 28d. Describe	tobacco use Yes 2 s an one) idence 6 how injury (Street and wn, State)	dd. Date of Month e contribute 24b. We pring dea 1 Other occurred Number	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death O
Cartification: To Be Completed by Dhysician/Madical Examiner	Medical Certification: 10 be Completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition if any, leading to immediate Sequentially list condition if any, leading to immediate Sequentially list can be sequentially listed to immediate Sequentially listed to immediate Sequential Sequent	gnant ths? It conditions o medical Pending investigation determined Certifying P. Medical Exa	Due to Dia b. Due to Dia b. Due to d. o (or as a co betes o (or as a co o (or as a	regnancy regnancy regnancy regnancy resulting in t	t enter the mod	regnancy pecify) DA Other Cause give Vicinity of the Vicinity	g, such as 26. Place 37. 4 □ Nu 31. 4. Yes 42. Yes 2 □	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only me 5 Ses 28d. Describe	tobacco use Yes 2 s an one) idence 6 how injury (Street and wn, State)	dd. Date of Month e contribute 24b. We pring dea 1 Other occurred Number	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Ons	
Certification: To Be Completed by Division/Medical Examiner	Medical Certification: 10 be Completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 montion of the past 12 montion of the past 12 montion of the past 12 montion of the past 12 montion of the past 12 montion of the past 13 montion of the past 14 montion of the past 15 montion of the p	gnant ths? gnant ths? tronditions ormedical Pending investigation Could not the determined Certifying P. Medical Exa	Due to Dia b. Due to Dia b. Due to d. o (or as a co betes o (or as a co o (or as a	regnancy regnancy regnancy regnancy resulting in t	t enter the mod	regnancy pecify) DA Other Cause give Vicinity of the Vicinity	g, such as 26. Place 37. 4 □ Nu 31. 4. Yes 42. Yes 2 □	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only me 5 Ses 28d. Describe	tobacco use Yes 2 s an one) idence 6 how injury (Street and wn, State)	dd. Date of Month e contribute 24b. We pring dea 1 Other occurred Number	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Ons	
Cartification: To Be Completed by Dhysician/Madical	Medical Certification: 10 Be Completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediates. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1	gnant ths? gnant ths? diate grant ths? conditions or medical Pending investigation Could not the determined of certifier of person who have year, year)	Due to Dia b. Due to Dia b. Due to Dia b. Due to d. Due	o (or as a co o	regnancy regnancy regnancy regnancy resulting in t	t enter the mod	regnancy pecify) DA Other Cause give Vicinity of the Vicinity	g, such as 26. Place 37. 4 □ Nu 31. 4. Yes 42. Yes 2 □	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only me 5 Ses 28d. Describe	tobacco use Yes 2 s an pormed? 2 No one) idence 6 how injury (Street and wn, State)	dd. Date of Month e contribute 24b. We pring dea 1 Other occurred Number	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death O
Modical Cartification: To Be Completed by Division/Medical Evaminer	medical Certification: 10 be Completed by Physician/Medical	shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediates. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg in the past 12 mont 1	gnant ths? It conditions o medical Pending investigation determined Could not to determined Certifying P. Medical Exa	Due to Dia b. Due to Dia b. Due to Dia b. Due to d. Due	o (or as a co location o (or as a co location	regnancy regnancy regnancy regnancy resulting in t	atient 3 Document or investigation	regnancy pecify) DA Other Cause give Vicinity of the Vicinity	g, such as 26. Place 37. 4 □ Nu 31. 4. Yes 42. Yes 2 □	cardiac	23e. Did 1 24a. Was auto perf 1 Yes n (Check only me 5 Ses 28d. Describe	tobacco use Yes 2 s an pormed? 2 No one) idence 6 how injury (Street and wn, State)	dd. Date of Month e contribute 24b. We pring dea 1 Other occurred Number	of delive	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death O

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Perium Delton Magee Apri1 26, 2005 2:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Health of Denton Denton Caroline If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2 □ F 82 Yrs. 217-12-4970 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MD Caroline Denton 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 420 Colonial Drive 21629 or items 23a United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2√XNo Specify: Specify: Black 3 Widowed 4 Divorced "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other then College (1-4or 5+) Elementary/Secondary (0-12) Locomotive Works Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental Himportent: If Item 27 is marked oth any injury or other treumatic even 2008. Be Robert Leonard Magee, Sr. Ethel Mae Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Hooper/Sister P.O. Box 362, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Federal Hill Cemetery 04/30/05 Federalsburg, MD `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit The law requires that the death certificate be executed ding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant been signed by the atter should be detached for u 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2.5 Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 HNo Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Director: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 32. Registrar's Signature Registrar

			for State Registrar	State of M	lar ylar	nd / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death	and M		iene (105	154	58
	Dhysia		1. Decedent's Name (First, Middle,								2. Date of Dea		Vaar	3. Time of D	eath
	Physic /Medi		Joan Young Mui	ray			,				April 1	9, 20	05 ^{Yeer}	7:55	РМ
	Examir	ner	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death		4c. Cou	unty of Death)	
			Montgomery Ger				If I in do.	01ne	y If Under	0411			ntgome		
	Funeral Director		5. Social Security Number 577-54-3640	5. Sex 7. A 1 M 2 F	69 (In yrs.	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth	rthplace (State or Foreign ountry)	
			Usual Residence of Decedent	21							Feb. 3,	1936	11.	linois	
	nylan how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City	Limits
	e Ma Sa-f s	cto	D.C. N/A		W	ashing	ton							M∑ Yes 2	2 No
	ith th	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cou	intry?	
	s 23a		1433 Locust Roa					0012					United States		
	Item de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceden Armed Forces d 1 Yes 2	?	.S. 13.	Was Deced f Yes, spec	dent of His cify Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto l	cify Yes or No- Rican, etc.)		Race - Amer Black, White		
936	al', or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2€ No	Specify:			SPE	ecify:	America	m
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show he Medical Exam art marker redified at	To Be Completed	15. Decedent's			16a. Dece				4 = 6 = 4.1			f Business/Ir		*11
21	thin 7		(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wo DO NOT u	rk done d se retired)	uring mosi)	t of workir	ng				
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "netural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam, or man be rediffied at once.			5+		Diagn	ostic				ialist		cation	1	
Maryland			17. Father's Name (First, Middle, L.	,					_		(First, Middle, I	Maiden Sun	name)		
ž	hould d Mer nark		Roy Mercer Your 19a. Informant's Name/Relationshi	-		40h M-10		(0)			Carson				
Ma	d 2 s th an t7 is i		James Hamilton		sband						Route Number)
ē	Heal Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of					on - City or T		-
JOE TO	ent of		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		9	emetery, crer incoln		•	·	4/25	/05				
Baltimore,	mit. Foortar		21. Signature of Funeral Service Li				Name an			У		but rts	illu, Fl	aryland	
m	9 9 E 8 8		Indré Il	10 mpser		7 M	cGuir 400 G	e fu eorg	neraJ ia Av	L Ser ze. N	vice .W., Wa	shing	ton. I).C. 20	012
Records, P.O. Box 68760,	Medical burial-transit the burial-transit	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Line Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a conseq 1S eps s a conseq	ileption		У						Onset and De	ath
	The law requires that the death certificate I lie has been signed by the attending physicale 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Feta	Ideath 3	Ectopic pro Other (sp					1	Date of deliv Month	ery Day Yea	ar
	puires that n signed t										Did tobacco use contribute to the cause of				
CO	as been si 2 should		Short Bowel Sy	ndrome his	torv	of res	ectio	nn.			24a. Was ar	1 24	b. Were auto	ppsy findings ava	ailable
	The la ate has page 2		Malnutrition								autops perform	ned?	prior to co death? 1 Yes	mpletion of caus	se of
Vital		BeC	25. Was case referred to medical						26. Place	of Death	(Check only one	No No	10 103	2010	
<u>></u>	S D	10 E	examiner? 1 □ Yes 2 🛣 No	Hospital: 1 💢 Inpati	ent 2	ER/Outpatien	t 3 🗆 DO	A Other	r: 4 🗆 Nur	rsing Hom	e 5 🗆 Reside	nce 6 🗆 0	Other (Specif	(y)	
D D	ding Ph h. After thi funeral	Certification:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 XNatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?					2.	28d. Describe how injury occurred						
20	ten feat tor: the										tion (Street and Number or Rural Route Number, or Town, State)				
Division of	if or Attendate after death Director:														
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edicai C	29a. Certifier 1 X Certifying (Check only one) 2 Medical Ex	Physician: To the best ceminer: On the basis of and manner st	of examinal	wledge, death tion and/or inv	occurred a	at the time in my opi	e, date and inion, deat	d place, ar	nd due to the ca	use(s) and te and plac	manner as s	tated. the cause(s)	
	To 1 withi To 12 comp	Ň	29b. Signature and title of certifier	-10xel	_		29c	License	number		29	d. Date sig	ned (Month,	Day, Year)	
	(III)		1	Je005/	0)		D5	0545			A	pril	21, 20	005	
	20		30. Name and address person w												
gar			Godswill 0. Ol				Hamps	hire	Ave	., Ta	koma Pa	rk, M	D 2091	.2	
	Sta Registr		31. Date filed (Month, Day, Year) APR 22	2005 32 Regist	ai s Signa	K Sol	A SE								

DHMH 17 Rev 1/2001

		Decedent's Name (First, Middle	M #5 per f	h g845 7/14	ertificate of Death	2. Date of Dea Month		3. Time of Dear
ysicia Iedic		Rudolph J. Max	xa			April	19, 2005	4:40 P
amin	er	4a. Fecility Name (If not institution			4b. City, Town, or Location of De	ath	4c. County of Deat	th
		Shady Grove Adv		pital . Age (In yrs. last birthda)	Rockville If Under 1 Year If Under 24 H	re la para (Bist	Montgomer	
eral ctor	-	5. Social Security Number 282-10-2308 Usuel Residence of Decedent	1 X M 2□F	87 Yrs.	Months Days Hours Mi		, Year) Co	thplace (State or For buntry) Lo
ä		10a. State 10b. County	/	10c. City, Town or I	Location			10d. Inside City Lin
beij	tor	MD Montgo	omerv	Gaithers	shure			1 ☐ Yes 2 🕎
E DO	Director	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What Co	ountry?
	rait	11412 Flints G	rove Lane		20878		U.S.A.	
	by Funeral	11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	If Yes Give	□No 1942-	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2 X No Specify: 	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
	Completed	(Specify only higher	nt's Education est grade completed)	16a. Dec (Giv	cedent's Usual Occupation we kind of work done during most of w . DO NOT use retired)	vorking	16b. Kind of Business/	Industry
	mo	Elementary/Secondary (0-12)	College (1-4	or 5+)	enant Colonel		U.S. Army	,
	BeC	17. Father's Name (First, Middle,	Last)			lame (First, Middle, i		
	ToE	Joseph Baburel	k		Nettie	Antonia		
		19a. Informant's Name/Relations	ship (Type, Print)		iling Address (Street and Number or			Zip Code)
10		Louis M. Prover	nzano, Neph		Gale Road, Gran			
1	-	20a. Method of Disposition 1 □ Burial 2 X Cremation	3 □Removal from St	ara i *	rematory or other place)		20c. Location - City or	
once.		'4 □Donation 5 □Other (S			oln Crematory 04/			Maryland
Duce		2) Signature of Fun val Service	Lightsee		22. Name and Address of Facility S			
-	-	23a Part I Enter the disease of	r complications that can	and the death Do not or	1040 Rockville Pi			Approximate
n al er		shock, or hear failure. List Immediate Cause (Final disease or condition resulting in death)	a. Uros Due to (or	epsis as a consequence of):				Interval Betweer Onset and Deat Clary S
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):				
1	Exan	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):				
	dical		d					
	0							
	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ⇒ No		h 2 Fetal death 3 It at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ② ☐ No	1□Live birth 4□Pregnan 9□Unknow	h 2 Fetal death 3 at at time of death 5 n	Other (specify)	23e. Did tot		Day Year
	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②ÆNo 9 ☐ Unknown	1□Live birth 4□Pregnan 9□Unknow	h 2 Fetal death 3 at at time of death 5 n	Other (specify)	23e. Did tot	Month acco use contribute to	Day Year
	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②ÆNo 9 ☐ Unknown	1□Live birth 4□Pregnan 9□Unknow	h 2 Fetal death 3 at at time of death 5 n	Other (specify)	1 □ Ye	Month acco use contribute to as 2 No 3 Pro	the cause of death
	ompleted by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②ÆNo 9 ☐ Unknown	1□Live birth 4□Pregnan 9□Unknow	h 2 Fetal death 3 at at time of death 5 n	Other (specify)	1 ☐ Ye 24a. Was al autops perform	Month pacco use contribute to us 22 No 3 Pro 24b. Were aul prior to colored?	the cause of death bably 4 Unkni topsy findings avail
	e Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ② ☐ No 9 ☐ Unknown Part II. Other significant condition 25. Was case referred to medical	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow ons contributing to deat	h 2 Fetal death 3 at at time of death 5 n	Underlying cause given in Part I.	1 ☐ Ye 24a. Was al autops perform	Month pacco use contribute to use 2 No 3 Pro 24b. Were aul prior to cleat to cleat No 1 Yes	the cause of death babbly 4 Unknown topsy findings available or cause
	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant condition	1 Live birth 4 Pregnan 9 Unknow ons contributing to deat Hospital:	h 2 Fetal death 3 It at time of death 5 In the but not resulting in the	underlying cause given in Part I.	24a. Was al autops perform 1 Yes 2	Month pacco use contribute to use 2 No 3 Pro 24b. Were aul prior to cleat to cleat No 1 Yes	the cause of death obably 4 Dunkni topsy findings availation of cause
	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes ② □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 □ Yes ○ No 27. Manner of Death	1 Live birth 4 Pregnan 9 Unknow ons contributing to deat Hospital: Inp	h 2 Fetal death 3 It at time of death 5 In the but not resulting in the	underlying cause given in Part I. 26. Place of D. ent 3 DOA Other: 4 Nursing of 28c. injury at Work?	24a. Was al autops perform 1 Yes 2	Month pacco use contribute to as 2 No 3 Pro prior to c death? 1 Yes a) nce 6 Other (Spec	the cause of death obably 4 Dunknitopsy findings available of cause
	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnan 9 Unknow ons contributing to deat Hospital: Inp 1 28a. Date of i (Month,	attent 2 ER/Outpatie	underlying cause given in Part I. 26. Place of Dient 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autops perform 1 Yes 2 eath (Check only on Home 5 Reside 28d. Describe ho	Month Dacco use contribute to us 2 No 3 Pro 24b. Were aul prior to c death? 1 Yes e) nce 6 Other (Spec w injury occurred	the cause of death' obably 4 Unknown topsy findings availation of cause 2 No
	ertification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Natural 5 Pendin	Hospital: Hospital: Hospital: Imp	h 2 Fetal death 3 It at time of death 5 In the but not resulting in the state of the but not resulting in the state of the but not resulting in the state of the but not resulting in the state of the but not resulting in the state of the but not resulting in the but not r	underlying cause given in Part I. 26. Place of Dient 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autops perform 1 Yes 2 eath (Check only on Home 5 Reside 28d. Describe ho	Month pacco use contribute to as 2 No 3 Pro prior to c death? 1 Yes a) nce 6 Other (Spec w injury occurred	the cause of death obably 4 Unknown topsy findings availation of cause 2 No
	dical Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 2 Accident 1 Natural 1 Natural 2 Natural 1 Natural 2 Natural 1 Natural 2 Natural	1 Live birth 4 Pregnan 9 Unknow Ons contributing to deat Hospital: Inp 1 28a. Date of I (Month, igation not be nined 28e. Place of building, ng Physician: To the be Examiner: On the basi	at at time of death 3 at at time of death 5 nn the but not resulting in the state of the but not resulting in the state of the but not resulting in the state of the but not resulting in the but n	underlying cause given in Part I. 26. Place of Dient 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autops perform 1 Yes 24a. Was an autops perform 2 eath (Check only on 2 eath (Check only on 2 eath (Check only on 2 eath (Check only on 3 eath (Location (St. City or Town 2 each due to the see	Month pacco use contribute to as 2 No 3 pro no 24b. Were aut prior to c death? 1 yes a) noce 6 Other (Spec w injury occurred	the cause of death' obably 4 Unknot topsy findings avails completion of cause 25 No cify)
	ertification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnan 9 Unknow In Hospital: Inp 1 28a. Date of ing 1 (Month, ing) 1 28e. Place of building, 1 1 1 1 1 1 1 1 1 1	attent 2 ER/Outpatie Injury At home, farm, si, etc. (Specify) ass of examination and/or in stated.	underlying cause given in Part I. 26. Place of D. 26. Place of D. 27. Place of D. 28. Injury at Work? M 1 Yes 2 No street, factory, office	24a. Was an autops perform 1 Yes seath (Check only on Home 5 Reside 28d. Describe house, and due to the capurred at the time, day	Month pacco use contribute to as 2 No 3 Pro prior to c death? 1 Yes a) nce 6 Other (Spec w injury occurred reet and Number or Rui , State) ause(s) and manner as atte and place, and due add. Date signed (Month	the cause of death' obably 4 Unknot topsy findings avails completion of cause 2 No call to the cause (s) of
	edical Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnan 9 Unknow In Hospital: Inp 1 28a. Date of ing 1 (Month, ing) 1 28e. Place of building, 1 1 1 1 1 1 1 1 1 1	attent 2 ER/Outpatie Injury At home, farm, si, etc. (Specify) ass of examination and/or in stated.	underlying cause given in Part I. 26. Place of D. 26. Place of D. 27. Other: 4 \(\text{ Nursing of Work?} \) 1 \(\text{ Yes 2 } \) No street, factory, office 29c. License number	24a. Was an autops perform 1 Yes seath (Check only on Home 5 Reside 28d. Describe house, and due to the capurred at the time, day	Month pacco use contribute to as 2 No 3 Pro prior to c death? 1 Yes a) nce 6 Other (Spec w injury occurred reet and Number or Rui , State) ause(s) and manner as atte and place, and due add. Date signed (Month	the cause of death' obably 4 Unknot topsy findings avails completion of cause 2 No call to the cause (s) of
	edical Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	Inguilary and the building. It Hospital: Input 28a. Date of information (Month, inguilary) and manner are who completed cause of the birth and manner are who completed cause of the birth and manner are who completed cause of the birth and manner are who completed cause of the birth and manner are who completed cause of the birth and manner are the birth and manner are the birth and the birt	attent 2 ER/Outpatie Injury At home, farm, s, etc. (Specify) as of examination and/or in stated.	underlying cause given in Part I. 26. Place of D. ent 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No street, factory, office ath occurred at the time, date and place investigation, in my opinion, death occurred at the time of the property of the proper	24a. Was an autops perform 1 Yes 2 eath (Check only on 28d. Describe house 28d. Descri	Month pacco use contribute to as 2 No 3 Pro no 24b. Were authorized to death? No 1 Yes a) nnce 6 Other (Spec w injury occurred reet and Number or Rui, State) stee and place, and due and Date signed (Month April 20	the cause of death bably 4 □Unkn topsy findings avail completion of cause 2 □ No ral Route Number, stated. to the cause(s) 7 Day, Year) 2 □ O S

			For Stata Registrar	State of	Marylan		artmen rtificat			nd Me		giene Reg. No.	005	15470
	L		1. Decedent's Name (First, Middle, La	st)							. Date of De. Month		Year	3. Time of Death
	Physicia /Medic		Dorothy Manseau	1							pril 1			11:40 A M
	Examin		4a. Facility Name (If not institution, giv		ber)				Location o	f Death			County of Dear	
			5609 Namakagan I		Ann (In	la a é bárbara d	Beth	esda 1 Year	If Under 2	24 Hrs o	. Date of Bir		ntgome	thplace (State or Foreign
	Funeral Director		5. Social Security Number 6. S 577-84-4014	1 M 2 AF	. Age (In yrs. I 100	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	Co	York
		1	Usual Residence of Decedent		100					b	ury /,	150	74 INCW	TOLK
	yland	Ī	10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	Mar Filed	io	Maryland Montgome	ery	Beth	esda								1 X Yes 2 □ No
	th the	Oire.	10e. Street and Number				10f. Zir	Code				10g. Citi	zen of What Co	ountry?
	23e	Funeral Directo	5609 Namakagan I				208			1.0.10		U.S.		
	er de	nue	11. Marital Status	12. Was Deced	ces?	.S. 13.	Was Dece If Yes, spe	dent of Hi city Cuba	spanic Orig n, Mexican	n? (Speci , Puerto Ri	fy Yes or No can, etc.)	-	14. Race - Ame Black, Whit	
30	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Wildowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Dat)		1 🗆 Yes	2 X No	Specify:				Specify: Wh	nite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Id other than "natural", or Items 23e or 28e-f show other than "natural", or Items 23e or 28e-f show event, I'te Medical Examinar must be notified at	ed	15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ation			16b. K	ind of Business	/Industry
212	nin 72	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-	4or 5+)	(Give	DO NOT u	se retired	iunng mosi)	of working	,			
77	filed withi Hygiene. other than ent, the w	mo:	12			Homer	naker						Home	
2	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last	"							First, Middle	Maiden	Sumame)	
<u>ya</u>	Ment Ment arkec	2	Robert Hess							se Ke				
a	2 should be 1 and Mental I is marked o raumatic eve	1 0	19a. Informant's Name/Relationship										r Town, State,	
<u>გ</u>	1 and Health em 27 ther tr		Lani Manseau	ı / Daugh						t Bla	- ,		Mary Lat ocation - City or	nd 20710 Town, State
Baltimore,	Pages 1 nent of H ant: If Ite		1XXXBurial 2 ☐ Cremation 3 [nate	Place of Disponentery, cre			6.14		. 2005			
Ħ	t. Partmer rtant		* 4 □ Donation 5 □ Other (Special Signature of Funeral Servica Lice		Arlı	ngton				v Inna			s Sons	Virginia
Ba	permit. Pages 1 and 2 should be filled Ingorant of Healin and Menial Hygi Importants if Item 27 is marked other any injury or other traumatic event. I Once.		21. Signatura Si Punolai Solvica Cico	Port	Zon						-			DC. 20016
			23a. Part 1. Enter the disease, or con	inplications that ca	used the deat								ing con,	Approximate Interval Between
Ц			shock, or heart failure. List only Immediate Cause (Final			II	E-41.							Onset and Death 5 years
	Pnysician /Medical		disease or condition resulting in death)	a	estive orasaconseq		rall	ure						J years
ř.	Examiner		20.000	b										
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (d	or as a conseq	uence of):								
	ocuted and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a conseq									
8760,	cate be executed oblysician and the burial-transit	ũ	rosulting in dodity cast	Due to (c	or as a conseq	uerica or).								
87	The law requires that the death certificate be executed at the seen signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	1.0	d										
9 X	death certifical attending phase as the	Physician/Me	IF FEMALE:	23c. If yes, outo									23d. Date of de	livery
Вох	atter atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?	4 ☐ Pregna	rth 2 ☐ Feta ant at time of d		□Ectopic p □ Other (s						Month	Day Year
P. O.	that the de led by the a detached f	hys	1 ☐ Yes 2 👿 No 9 ☐ Unknown	9□ Unkno	wn						-			
	w requires that s been signed to should be deta	by PI	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the	underlying	cause giv	en in Part I					o the cause of death?
ğ	an sig										1 🗆	Yes 2	CXNo 3∏P	robably 4 Unknown
S	law re	plet									24a. Was		24b. Were a	utopsy findings available completion of cause of
æ	The lay	Completed									perfe	ormed?	death?	s 2 No
of Vital Records,	lending Physicien: The leath. tor: After this certificate hithe funeral director, page	Be C	25. Was case referred to medical examiner?								(Check only			
Ž	Physicien: r this certificatal director,	2	1 ☐ Yes 2 No	-		ER/Outpatie							6 ☐Other (Spe	ecify)
	ding P. h. After t	on:	27. Manner of Death 1 X Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time Injury		28c. Injur Wor	k?		3d. Describe	how inju	ry occurred	
sio	Attending r death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not	he	of Injune - At h	ome farm c	M tract facto		Yes 2 🗆		of Location	Street au	nd Number or F	lural Route Number,
Division	l or Attendation of the I or Attendation of the I or I or I or I or I or I or I or I o	ertification:	4 Homicide determine	d 200. Place buildir	of Injury - At h ng, etc. (Special	ly)	treet, racto	ту, описы			City or To	wn, State	9)	ara. Froato Francor,
J	To the Hospitel or At within 24 hours after or To the Funeral Diract completely filled in by	O	29a. Certifier	Physician: To the	best of my kno	owledge, dea	th occurre	at the tir	ne, date ar	nd place, ar	nd due to the	cause(s) and manner a	s stated.
	24 h 24 h e Fur	edical	(Check off) 2 Medical Ext	aminar: On the ba	asis of examina	ation and/or i	nvestigatio	n, in my o	pinion, dea	th occurred	d at the time.	date an	d place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	//		_	-		e number				ite signed (Mon	
)	10		MAD LY	tur	m	2/19		D320	33			Apri	il 20,	2005
	(-		30. Name and address of person who	o completed caus	e of death (Iter	m 23a) (Type	, Print)							_
_			Peter Hamm, M.D						Chevy	Chas	e, Mar	:y1aı	nd 2081.	5
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 2	2005	egistrar's Sign	ature A	cele							

			For State Registrar	State of M		epartment of Certificate of		ind Mental H	ygiene	005	15471
	*_ 1		Decedent's Name (First, Middle, La	st)				2. Date of D			3. Time of Death
1	Physic		Kathleen	P.	Malley			Month April	18, 2	Year 005	7:45 P M
3	/Medi Examir		4a. Facility Name (If not institution, given	re street and number)	4b. City, Tow	n, or Location o			unty of Death	7.43
	LAGIIII		Manor Care- Che	vy Chase			Chevy C	hase.		Monto	omerv
	Funeral				ge (In yrs. last birth		ear If Under 2	4 Hrs. 8 Date of F	irth	9. Birthp	olace (State or Foreign
	Director		215-50-2663	1□ M 2⊠F	96 Yr	s. Months Da	ys Hours		Da <i>y, Year)</i> .6. 190	8 Ten	nessee
	TO		Usual Residence of Decedent					10 01.10	.0, 250	O ICII	
	how		10a. State 10b. County		10c. City, Town o	r Location				1	0d. Inside City Limits
	e Ma	cto	Maryland M	ontgomery	Che	vy Chase					1 ☐ Yes 2 및 No
	ih th	ire.	10e. Street and Number			10f. Zip Cod	e		10g. Citizen	of What Cour	ntry?
	23s	ai	3614 Thornappl	e Street		208	15			USA	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If terms 23s or 28s-f show amy injury or other traumatic event, the Medical Exart set in the best side and once.	Funer	11. Marital Status 1 Never Married 2 Married	12. Was Deceden Armed Forces 1 □ Yes 2 🔀	?	If Yes, specify C	Cuban, Mexican	in? (Specify Yes or N Puerto Rican, etc.)		Race - Americ Black, White,	
003	hours a tural', o	ed by	3 ☑ Midowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 I ecedent's Usual Oc				ecity:Whit	
21215-0036	ithin 72 ne. nen "ne.	npiet	(Specify only highest gr. Elementary/Secondary (0-12)			give kind of work do fe. DO NOT use re	ne during most	of working	160. Kind	or Business/in	dustry
	ygier ygier it, it.	S	12			Secretar					ernment
Maryland	be first H	Be	17. Father's Name (First, Middle, Last Bascom Wood Pen					rs Name <i>(First, Midd.</i> y Elizabet			_
$\frac{8}{2}$	ould Men Marke Larke	ဥ									
131	2 sh and Is m		19a. Informant's Name/Relationship					r or Rural Route Num			
	and lealth m 27 her t	1 8	Kathleen Montag	ue/Daughte				reet, Chev			
ö	Jes 1	1	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery,	isposition (Name of crematory or other p	place)	May 10,	20c. Locat	ion - City or To	own, State
E	Pag men tant: jury		' 4 ☐ Donation 5 ☐ Other (Speci	(y)	Arlington	National C		2005			irginia
Baltimore,	Departiment Departiment Important In Sunce.		21. Signature of Funeral Service Lice	J. Silvis		Francis J 500 Unive	dress of Facility Collinersity	ns Funera Blvd, W, S	l Home Silver	Inc. Spring	.MD 20901
À.	8		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do not						Approximate Interval Between
S.	Physician		Immediate Cause (Final								Onset and Death
	/Medical		disease or condition resulting in death)	- w.	tion Pneum saconsequence of)					-	1 Week
4	Examiner										
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence of)						
	outed ansil	Examiner	Cause (Disease or injury that initiated events	c.							
o Î	an ar rial-tr	EX	resulting in death) Last	Due to (or as	a consequence of)						
8760,	cate be executed physician and the burial-transit	dicai	•	d							
9		led									
ROX	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Petal death	3 ☐Ectopic pregna	IDCV.		23d.	Date of delive	эгу
n.	0 0 0	icia	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant a	at time of death	5 ☐ Other (specify,				Month	Day Year
Ö.	that the de led by the a detached t	hys	9 Unknown	9□ Unknown							
S, T	The law requires that the ate has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions		but not resulting in th	e underlying cause	given in Part I.	23e. Did	tobacco use	contribute to th	ne cause of death?
Ď	w require been sig should b		Cerebrovascular	Disease				1	Yes 2X∑N	o 3 🗆 Prob	abiy 4 ∐Unknown
Record	s bed 2 sho	Completed						24a. Wa		4b. Were auto	psy findings available
Ĕ	The lav	mo						per	opsy formed?	death?	inpletion of cause of
g		a)	25. Was case referred to medical				as Plans	1 ☐ Yes of Death Check onl		1 🗆 Yes	2 🗆 No
>	Physician: this certificand director,	0 8	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Ulnnat	ient 2 ER/Outp	atient 3 DOA		sing Home 5 Re		Other (Conside	
ō	ding Phy h. After this funeral c	H	27. Manner of Death	28a. Date of Inj (Month, D.		ie of 28c. Ir	njury at		how injury or		()
0	nding th. : Afte	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		a <i>y Year)</i> Inju		Work? ∐Yes 2∐N	lo			
Division of Vital	or Attending after death. Director: After in by the fune	fice	3 ☐ Suicide 6 ☐ Could not b	286. Place of in	njury - At home, farm	, street, factory, office	ce	28f. Location	(Street and N	umber or Rura	l Route Number,
á	- 0 -	Certification:	4 Homicide	building, e	tc. (Specify)			City or To	own, State)		
	To the Hospital of within 24 hours aff To the Funeral Discompletely filled in	edical C	29a. Certifier 15 Certifying P (Check only one)	miner: On the basis	of exagrination and/o	leath occurred at the or investigation, in m	e time, date and ly opinion, deat	place, and due to the	e cause(s) and o, date and pla	d manner as st	ated. the cause(s)
	thin 2 the mplel	Med	29b. Signature and title of certifier	and manner s	lal90r		ense number			gned (Month, i	
	T W T 8		Dan 4	1/1	anler	no)	004179				
			MIN		U. VILL	1110	70#I/9		April	19, 20	05
	15		_ 200 /.	completed conserver							
			James J. Fost	er, M.D.	5530 Wis	consin Av	enue, C	Chevy Chas	e, MD 2	20815	
	Sta Regist		31. Date filed (Month, Day, Year)	ns Hagis	trar's Signature	MARINE S					
	negist	(ell	HYK GG C	J. B. Park	1 1 1						

DARYL C.PRETTY 05-2073 DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 11 per fb 8843 5-5-05 vt

,			1 - For State Registrar	State	of Maryland		artment of <i>tificate o</i>		and M		eg. No.	005	15473
	Di.		1. Decedent's Name (First, Middle	, Last)			*			2. Date of Dea Month	th	V	3. Time of Death
	Physici /Medi		Daryl Carter Pi	retty						MARCH	23,	2005	12:34a M
	Examir	ier	4a. Facility Name (If not institution, PRINCE GEORGES				4b. City, Town		f Death			ounty of Death	Dana
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea		24 Hrs.	8. Date of Birth		NCE GEO	
	Director		083-58-0248	1 🔀 M 2 🗆 F	38	Yrs.	Months Day	's Hours	Min.	(Month, Day, 04 25	66	Coun	lace (State or Foreign litry)
	and		Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City	, Town or Lo	cation						Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show Litust be notified at	tor	MD Prince	Georges		nsvil							1 ☐ Yes 2 ☐ No
	r 28a	lrec	10e. Street and Number	0001 803	OI OW	/IIS VII.	10f. Zip Code	•		1	0g. Citizer	n of What Coun	itry?
	23a c	al D	1048 Tudor Dr.				21032				US	SA	
9		Funeral Director	11. Marital Status 1 Never Married 2 Marri	Armed F	2 1 No		Was Decedent of f Yes, specify Cu I ☐ Yes 2 1 N	ıban, Mexican	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	etc.
21215-0036	2 should be filed within 72 hours after and Mental Hyglene. Is marked other than "naturat", or its marked other than "naturat" surmitic avent, it is Modical Examilia	ed by	3 Widowed 4 □ Divorced	Year or I	Dates:							pecify: Blk	
15-	in 72 n "nat	Completed	15. Decedent (Specify only highes	t grade completed,		16a. Deced (Give life. I	lent's Usual Occ kind of work don DO NOT use reti	upation le during most red)	of worki	ng	16b. Kind	of Business/Inc	dustry
212	giene giene ar tha	mo.	Elementary/Secondary (0-12)	1	(1-4or 5+)	Drive	r				Trans	sportati	ion
nd	uld be file Aental Hy rkad oth tic avant	Be	17. Father's Name (First, Middle, L							(First, Middle, I			
Maryland	d Men marka matic	J.	Kenneth I. B. I			105 Mailie	a Address (Can			Carter P			
	of 2 sulth an 27 is i		Kenneth I. B. Pr		athor					NY 113		own, State, Zip	Code)
re,	of Hea itam other		20a. Method of Disposition		20b. P!		sition (Name of natory or other p					tion - City or To	wn, State
Ë	Page ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Olato		ove Chur		3 26	05 0:	range	Co. VA	A
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other tra <u>QDCe.</u>		21. Signature of Funeral Service L	1 12	n CC 020		Name and Add	ress of Facility s Fune	ral	Hm. P.O			
			23a. Par 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the death.	Do not ent	er the mode of d	ying, such as o	ardiac c	r respiratory arre	est,		Approximate Interval Between
	Pnysician /Medical-		Immediate Cause (Final disease or condition resulting in death)	_a M	ultiple	14/6	ries						Onset and Death
	Examiner			Due to	(or as a consequ	ence of.							
- 29		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a consequ	ence of):							
V	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
68760,	be exician i	al E		Due to	(or as a conseque	ence or):							
687	ificate be g physicia as the bur	edical		d									
Вох	eath certiff attending I for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnan		Ectopic pregnan	ICV			23d	. Date of deliver	ry
O. E	0 0 0	ysicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of dea		Other (specify)				:	Month	Day Year
۵.	requires that the de een signed by the a nould be detached t	y Ph	Part II. Other significant condition	ns contributing to d	leath but not resul	ting in the ur	derlying cause g	given in Part I.		23e. Did tob	acco use	contribute to the	e cause of death?
of Vital Records,	w requires that been signed to should be deta	ed by								1 □ Ye	s 2 🗆 N	lo 3 Proba	ably 4 Unknown
000	aw Is b	plete								24a. Was ar		4b. Were autop	sy findings available
E B	The ate h page	Completed								autopsy perform		death?	npletion of cause of 2□ No
Vita	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						(Check only one			
of	Phys r this sral di	To To	XXYes 2 No 27. Manner of Death	28a. Date	of Injury	R/Outpatient 28b. Time of	3 □ DOA 28c. Ini	urv at	sing Hor	ne 5 🗆 Reside	nce 6	Other (Specify)	accillent
ion	Attanding Franching Franching Control of the funer by the funer	atior	1 □ Natural 5 □ Pending 2 ★ Accident investig	01 1	th, Day Year)	Injury	28c. inj W M 1[ork? ⊒Yes 2 ∑ N		rive inve			
Division	or Attano after deat Diractor: In by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ned 286. Place	e of Injury - At hor ling, etc. (Specify)			9	2	8f. Location (Str City or Town	eet and N	umber or Rural	Route Number, MI)
D	pital o urs aft aral Di		00-0-17-			Stre				rais Hwy	oud V		upper Marks
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☒ Medicel E	Physician: To the ixaminer: On the b and man	e best of my know easis of examination oner stated.	fiedge, death on and/or inv	occurred at the estigation, in my	time, date and opinion, death	place, a occurre	and due to the ca ed at the time, da	use(s) and ite and pla	d manner as sta ce, and due to	ated. the cause(s)
	To th within To th. compl	Me	29b. Signature and title of certifier	7 4 2			29c. Licer	nse number	·	29	d. Date si	gned (Month, E	Pay, Year)
			> Cabrill	ah Al	7			OCME		N	1ARCH	23, 2	005
	5		30. Name and address of person w	tho completed cause	se of death (Item :	23a) (Type, I		Penn St	reet	E Balti	more,		and 21201
* 3	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signatu	ire							

			1 - For Amend item#23	State of M PI, 28d, e,f	laryland, perME,	/ Depa	artmen rtificat	t of H e of L	ealth ai <i>Death</i>	nd Me	ental Hy	giene Rag. No.	2005	15471
	Physici /Medic		1. Decedent's Name (First, Middle, Mabel	Last)		Sheet	s				2. Date of Dea		2005 ^{Year}	3. Time of Death 3:50pm M
	Examir		4a. Facility Name (If not institution, g Frederick Mem]	Frede	Location of	Death		4c.	County of Deat Frederi	ck
	Funeral Director		5. Social Security Number 577-34-1334 Usual Residence of Decedent	. Sex 7. A 1 □ M 2 1 F	102	Yrs.	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	B. Date of Birt Jan I	7^{Year}	9. Birt 903 Mar	hplace (State or Foreign cyland
	Maryland I-f show	tor	10a. State 10b. County Maryland Freder	rick	10c. City,	Town or Lo								10d. Inside City Limits
3	death with the Maryland ms 23a or 28a-f show	ai Director	10e. Street and Number 5955 Quinn Or	chard Road	l		10f. Zip		.704			10g. Citi	zen of What Co	ountry?
		by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 New Year or Dates	? No		Was Deced f Yes, spec 1 Yes	cify Cubai	spanic Origi n, Mexican, Specify:	in? (Spec Puerto R	rify Yes or No- lican, etc.)	-	14. Race - Ame Black, White Specify: Wh	
0-61717	filed within 72 nours after Hygiene. other than "natural", or fte ant, gre Madical Exacilina	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4o	r 5+)	life.	dent's Usua kind of wo DO NOT u	rk done d se retired)	urina most d	of workin	g		ind of Business/	•
Ξ.	0 5 5 0	To Be C	17. Father's Name (First, Middle, La Harry Lee			- -					(First, Middle, lae Hi	Maiden	Sumame)	
, Mary	s 1 and 2 should f Health and Men fem 27 is marke other traumatic		19a. Informant's Name/Relationship Mrs. Carol Dimmi		ghter	2876	E. 1	Hicko					r Town, State, 2 City, Ir	zip Code) 46725 ndiana
altimore	Page nent o ant: # ury or		20a. Method of Disposition 12 Surial 2 Cremation 3 4 Donation 5 Other (Spe		e Mou	netery creating Oli	sition (Nai natory or o Vet Ce	me of other place Meter	y May	3, 20			lerick,	
Dall	pernit. Departir Importa		21. Signature of Funeral Service Lie	John	M00255								al Home k, MD 2	21701
	hysician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Pne Due to (or a	umonia s a conseque		er the mod	de of dying	, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
7	nsit	Examiner	Sequentially list conditions, any, leading of introductions cause. Enter Underlying Cause (Disease or injury		us sanonseque ht Int		chant	eric	Hin	Frac	ture			3 days 10 days
8/00,	death certificate be executed e attending physician and id for use as the burial-transit	dical Exar	that initiated events resulting in death) Last	C	s a conseque				P					
O. Box 6	the death certific y the attending p iched for use as	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown		e of pregnand 2 ∏ Fetal d at time of dea	eath 3	Ectopic pi					1	23d. Date of deli Month	ivery Day Year
ras, r	w requires that the debase signed by the should be detached	by P	Part II. Other significant condition Osteoporosis	s contributing to death	but not result	ing in the u	nderlying o	ause give	n in Part I.			obacco u res 2		the cause of death?
Hec	The law recate has been bage 2 shou	ompleted	Dementia Colon Cancer									sy rmed?	prior to death?	stopsy findings available completion of cause of
	ysician: is certifica director, I	To Be C	25. Was case referred to medical examiner? 1 🖫 Yes 2 🗌 No	Hospital: 1 🔀 Inpa	tient 2□Ef		nt 3 DO	Othe			(Check only o		5 ☐Other (Spec	
lon	ending sath. or: After he fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Naccident investiga 3 Suicide 6 Could no	t he	, 2005	8b. Time of Injury 6:45	am ^м			0	Fell w	hil c	gettir	0 11 111111
2	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determin	ed 288. Flace of the building,	tellent	Assis	ted Li	ving		Co	unity Me Road,	a dów: Fred	5955 (lerick,	ural Route Number, Quinn Orchar Maryland
	o the Hos ithin 24 hc o the Fun	Medical		Physician: To the best caminer: On the basis and manner:	of examinatio	n and/or in	vestigation	at the tim , in my op c. License	inion, death	piace, ar i occurre	d at the time,	date and	and manner as place, and due e signed (Monti	to the cause(s)
•			30. Name and address of person w	Hold to completed cause of	death (Item) 2	AU (Type	Print)	D37	197				y 2, 200	
	\0	ate_	Alan H. Rohrer	, M.D., 15	West S	Seven	th St	reet	, Free	derio	ck, Mar	rylaı	nd 2170	1
DHM	Regist	_	MAY 0 6 2	Regis	v K	April								

Registrar DHMH 17 Rev 1/2001

		Registrar				Timoato	of Death			Reg. No	UUU	1 4 1
iar		1. Decedent's Name (First, Middle,	Last)					2.	Date of Dea Month	ath Day	Year	3. Time of Death
ica		CATHER	INE ROSE	SANDE	RS			A	PRIL	29,	2005	11:15 P
ine	r	4a. Facility Name (If not institution,	give street and num	nber)		4b. City, Tov	wn, or Location of	of Death		4c. 0	County of Death	
		17670 SABILLAS					LLASVILI				REDERIC	
			6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs.	last birthday) Yrs.		ear If Under ays Hours	Min.	Date of Birt (Month, Da	h y, Yea <i>r</i>)	9. Birthp	place (State or Forei ntry)
		214-08-4433 Usual Residence of Decedent		36				J	ULY17,	1968	MARY	LAND
	-	10a. State 10b. County		10c. City	y, Town or Lo	ocation					1	10d. Inside City Limit
Š	ō	MARYLAND FREDI	ERICK		SARTI	LASVILI	Æ					1 ☐ Yes 2 🖾 N
004	Se	10e. Street and Number	JICI CIC		Dineil	10f. Zip Co				10g. Citiz	en of What Cour	ntry?
	2	17670 SABILLAS	SVILLE RD			217	780			U.S	.A.	
200	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13.	Was Decedent	t of Hispanic Ori Cuban, Mexicar	gin? (Specif	y Yes or No-	- 1	4. Race - Americ	
ü	2	1 ☐ Never Married 2 🔀 Marrie	Armed Fo	2 No					an, etc.)		Black, White,	
ì	þ	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e ates:		1 ☐ Yes 2 🖔	No Specify:			3	Specify: WHI	TE
2040	Completed	15. Decedent's (Specify only highest	s Education		16a. Dece	edent's Usual O	ccupation lone during mos	t of working		16b. Kin	d of Business/In-	dustry
100	du	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use n	etired)	i or working				
2	ဂ် ပ	12			HOM	(EMAKER				WO	N HOME	
a	Be	17. Father's Name (First, Middle, L	ast)				18. Mothe	er's Name <i>(F</i>	irst, Middle,	Maiden S	Sumame)	
F	၀	JOHN ANDREV	W PRICE				MAF	RGARET	TERES	SA Mc	CONNEL	•
		19a. Informant's Name/Relationsh	ip (Type, Print)								Town, State, Zip	
		DAVID BRIAN SAM	NDERS/HUS		_				-	LLASV	ILLE MD	. 21780
	1	20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from :		lace of Dispo semetery, cre	osition (Name o	of r place)	Date	9	20c. Loc	ation - City or To	own, State
1	1	`4 □ Donation 5 □ Other (Sp			EW ST.	JOSEPH	'S 5	/4/200)5	EMMIT	rsburg,	MD 21727
		21. Signatur o Funeral Service L	icensee /	1	2:	2. Name and A	ddress of Facilit	y SK	TLES E	UNER	AL HOME	
								DIC				
1		John m	Skil	es	2	210 W. N	MAIN ST.			RG, M	D. 2172	7
		23a. Part 1 Enter the disease, or condition resulting in death)	aDue to (aused the death ach line.		ter the mode of		EMM cardiac or re	ITSBUF	rest,	1.	Approximate Interval Between Onset and Death
Evaminor	Exa	shock/or heart failure. List of Immediate Cause (Final disease or condition	a	aused the death ach line. OCCUPATION OF AS A CONSEQUENT OF AS A CONSE	MA uence of):	ter the mode of	f dying, such as	EMM cardiac or re	ITSBUF	rest,	1.	Approximate Interval Between Onset and Death
lealba	edical	shock or heart failure. List of the shock of heart failure. List of the shock of th	a	ach line. Cocono or as a consequence as a consequence	MA uence of):	ter the mode of	f dying, such as	EMM cardiac or re	ITSBUF	rest,	1.	Approximate Interval Between Onset and Death
leallog	edical	shock or heart failure. List of the shock of heart failure. List of the shock of th	a	ach line. Or as a consequence of pregnarith 2 Feta and at time of dr	h. Do not en AMA uence of): uence of): ancy death 3[ter the mode of	f dying, such as	EMM cardiac or re	ITSBUF	rest,	1.	Approximate Interval Between Onset and Death
Dhyelolan/Modloal	Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary Jacon John Hotels cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	or as a consequence of pregnatifith 2 Feta and at time of diswin	uence of): uence of): uence of):	□Ectopic pregn	f dying, such as	cardiac or re	ITSBUF pespiratory ar	rest,	Bd. Date of deliver	Approximate Interval Between Onset and Death Succession of the Procession of the Pro
by Dhyelolan/Modical	by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tany Jacob John History Cause, Enter Underlying Cause, Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	a	or as a consequence of pregnatifith 2 Feta and at time of diswin	uence of): uence of): uence of):	□Ectopic pregn	f dying, such as	cardiac or re	ITSBUF espiratory ar	250 pbacco us	Bd. Date of deliver Month	Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset and Death The Approximate Interval Batween Onset Interval Ba
Jeoglaphy Dhyelolaphy Model	eted by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary Jacon John Hotels cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	or as a consequence of pregnatifith 2 Feta and at time of diswin	uence of): uence of): uence of):	□Ectopic pregn	f dying, such as	cardiac or re	ITSBUF espiratory ar	250 pbacco us	Bd. Date of deliver Month	Approximate Interval Between Onset and Death Survey Page 19 Pa
stod by Dhyelclan/Modical	eted by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary Jacon John Hotels cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	or as a consequence of pregnatifith 2 Feta and at time of diswin	uence of): uence of): uence of):	□Ectopic pregn	f dying, such as	cardiac or re	23e. Did to	23 Dbacco us /es 2 an	Bd. Date of deliver Month a contribute to the No. 3 (X) Proberties autoprior to contribute to contribute to the normal section of t	Approximate Interval Batween Onset and Death Seath Sea
ompleted by Dhyelclan/Medical	ompleted by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary Jacon John Hotels cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a	or as a consequence of pregnatifith 2 Feta and at time of diswin	uence of): uence of): uence of):	□Ectopic pregn	f dying, such as	cardiac or re	23e. Did to	23 bbacco us (es 2 an isy med?	Bd. Date of deliver Month a contribute to the No 3 X Proberation 24b. Were autoprior to codeath?	Approximate Interval Batween Onset and Death Seath Sea
Completed by Davelolan/Medical	e Completed by Physician/Medical	Sequentially list conditions, large land land land land land land land land	a	or as a consequence of pregnatifith 2 Feta and at time of diswin	uence of): uence of): uence of):	□Ectopic pregn	t dying, such as	cardiac or re	23e. Did to	23 bbacco us (es 2 □ an isy rmed? 2 ☒ No	Bd. Date of deliver Month e contribute to the No 3 🕱 Probes 24b. Were auto prior to codeath?	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Death Onset and Death Death Death Onset and Death Dea
Po Complete by Dhyelolan/Medical	Completed by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 and	a	or as a consequence of pregnatifith 2 Feta and at time of diswin	uence of): uence of): uence of): uence of): uence of): uence of): uence of): uence of): uence of):	□Ectopic pregn □ Other (specification)	nancy e given in Part I.	e of Death (C	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes Check only on	200 pobacco us (fes 2 an usy med? 2 No ne)	Bd. Date of deliver Month a contribute to the No 3 X Proberation 24b. Were autoprior to condeath? 1 Yes	Approximate Interval Between Onset and Death Death Onset and D
To Be Completed by Dhyelolan/Medical	To Be Completed by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary leading to many failure cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No No 27. Manner of Death	a	ach line. Or as a consequence or as a consequence of pregna inthe 2 Detail and at time of drown eath but not resumpatient 2 Definiury	uence of): uence of): uence of): uence of): uence of): ER/Outpatieu 28b. Time o	□Ectopic pregn □ Other (specification and arriving cause)	e given in Part I.	eardiac or re	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes Check only on	23 obacco usi fes 2 an an asyrmed? 2 No nel	Bd. Date of deliver Month a contribute to the INO 3 X Probect Prior to condeath? 1 Yes Other (Specific	Approximate Interval Between Onset and Death Death Onset and D
To Be Completed by Dhyelclan/Medical	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	or as a consequence of pregnantiant at time of down	uence of): uence of): uence of): uence of): uence of): ER/Outpaties	□Ectopic pregn □ Other (specification and arriving cause)	nancy e given in Part I.	of Death (Corsing Home	23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes Check only or 5 Aresid	23 obacco usi fes 2 an an asyrmed? 2 No nel	Bd. Date of deliver Month a contribute to the INO 3 X Probect Prior to condeath? 1 Yes Other (Specific	Approximate Interval Between Onset and Death Death Onset and D
owill cotton: To Be Completed by Diversion Modical Evaminer	To Be Completed by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, have leaved to investig cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Repending	Due to (b. Due to (c. Due to (d. 23c. If yes, out 1 Live b 4 Pregn 9 Unknowns contributing to de (Montation of be 28e. Place	ach line. Or as a consequence or as a consequence of pregna inthe 2 Detail and at time of drown eath but not resumpatient 2 Definiury	uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatier 28b. Time of Injury ome, farm, sti	□Ectopic pregn □ Other (specification of the context) and significant signif	ancy 26. Place Other: 4 Nu Injury at Work? 1 Yes 2	of Death (Corsing Home	23e. Did to 1 Y 24a. Was autop perfor 1 Yes Check only on 5 🛣 Resid 6. Describe h	23 obacco usi fes 2 an an ssy rmed? 2 No ne) dence 6 now injury	Bd. Date of deliver Month a contribute to the No. 3 (X) Problem 1	Approximate Interval Between Onset and Death Death Onset and D
Consistent of Do Completed by Dhysician Madical Evaminar	Certification; To Be Completed by Physician/Medical	Shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 and	Due to (b. Due to (c. Due to (d. 23c. If yes, out 1 Live b 4 Pregn 9 Unknown as contributing to de (months of be 28e. Place building Physicien: To the became on the building physicien: To the became of the pregners of the building physicien: To the became of the pregners of the building physicien: To the became of the pregners of the building physicien: To the became of the pregners of the	ach line. Or as a consequence or as a consequence of pregnarith 2 Feta ant at time of down or as a consequence or as a con	uence of): uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatien 28b. Time of Injury owledge, deat	□Ectopic pregn □ Other (specification of the cause) and 3□ DOA of 28c. M reet, factory, of	ancy 26. Place Other: 4 Nu Injury at Work? 1 Yes 2 I	of Death (Corsing Home 28d No 28f.	23e. Did to 1 Yes 24a. Was autopperfoi 1 Yes Check only on 5 Aresid 6. Describe h	bbacco us fes 2 an isy med? 2 No ne) dence 6 now injury	Bd. Date of deliver Month a contribute to the No. 3 X Prob. 24b. Were autoprior to condeath? 1 Yes Other (Specify occurred)	Approximate Interval Batween Onset and Death Sources and Death Sou
edical Cortification: To Be Completed by Dhysician/Modical	ledical Certification; To Be Completed by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary leading to many state cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (b. Due to (c. Due to (d. d. li Live b 4 Pregn 9 Unknowns contributing to de (Montation of be exeminer: On the became and manning to the exeminer: On the became of the contribution of the became of the contribution of the became of t	or as a consequence of pregna and at time of down of linjury. At h. Day Year) of Injury - At h. Day Year) best of my kno assis of examina fer stated.	uence of): uence	□Ectopic pregn □ Other (specific pregner) □ Oth	ancy 26. Place Other: 4 Nu Injury at Work? 1 Yes 2 I	p of Death (Corsing Home 28d No 28f.	23e. Did to 1 Yes 24a. Was a autop performed. Describe has continued in the time, of at the time, of at the time, of the second at the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in	23 bbacco us (es 2 an an est rmed? 2 No ne) dence 6 now injury Street and many, State) cause(s) a date and processed	Bd. Date of deliver Month a contribute to the No 3 X Prob 24b. Were autopier to condeath? 1 Yes Other (Specify occurred Number or Rura and manner as siplace, and due to signed (Month,	Approximate Interval Between Onset and Death Sources of June 1 and Death Sources of Ju
odical Cariffication: To Be Completed by Dhuelelan Modical Examiner	ledical Certification; To Be Completed by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary leading to many state cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (b. Due to (c. Due to (d. d. li Live b 4 Pregn 9 Unknowns contributing to de (Montation of be exeminer: On the became and manning to the exeminer: On the became of the contribution of the became of the contribution of the became of t	or as a consequence of pregna and at time of down of linjury. At h. Day Year) of Injury - At h. Day Year) best of my kno assis of examina fer stated.	uence of): uence	□Ectopic pregn □ Other (specific pregner) □ Oth	ancy 26. Place Other: 4 Nu Injury at Work? 1 Yes 2 I	p of Death (Corsing Home 28d No 28f.	23e. Did to 1 Yes 24a. Was a autop performed. Describe has continued in the time, of at the time, of at the time, of the second at the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in the time, of the second in	23 bbacco us (es 2 an an est rmed? 2 No ne) dence 6 now injury Street and many, State) cause(s) a date and processed	Bd. Date of deliver Month a contribute to the No 3 X Prob 24b. Were autopier to condeath? 1 Yes Other (Specify occurred Number or Rura and manner as siplace, and due to signed (Month,	Approximate Interval Between Onset and Death Sources and Death Sou
odical Cassistant To Be Completed by Division Madical Examiner	ledical Certification; To Be Completed by Physician/Medical	shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary leading to many state cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (b. Due to (c. Due to (d. 23c. If yes, out 1 Live b 4 Pregn 9 Unknown as contributing to de (months of be 28e. Place building Physicien: To the became on the building physicien: To the became of the pregners of the building physicien: To the became of the pregners of the building physicien: To the became of the pregners of the building physicien: To the became of the pregners of the	or as a consequence of pregna and at time of down of linjury. At h. Day Year) of Injury - At h. Day Year) best of my kno assis of examina fer stated.	uence of): uence	□Ectopic pregn □ Other (specific pregner) □ Oth	ancy 26. Place Other: 4 Nu Injury at Work? 1 Yes 2 I	p of Death (Corsing Home 28d No 28f.	23e. Did to 1 Yes 24a. Was a autop performed. Check only on 5 A Resid. Describe had been been been been been been been bee	23 bbacco us (es 2 an an est rmed? 2 No ne) dence 6 now injury Street and many, State) cause(s) a date and processed	Bd. Date of deliver Month a contribute to the No 3 X Prob 24b. Were autopier to condeath? 1 Yes Other (Specify occurred Number or Rura and manner as siplace, and due to signed (Month,	Approximate Interval Batween Onset and Death Source All Paragraphs of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death? Death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death?

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day John William Wright Scott 22, 2005 Apri 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8886 Watts Creek Lane Denton Caroline If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 □ **X** 2 □ F Director Nov.11,1927 Maryland 213-26-7190 77 Usual Residence of Decedent filed within 72 hours after deeth with the Marylend 10b. County 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic avent, the Modical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? United States of Completed by Funeral 8886 Watts Creek Lane 21629 America 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 GYes 2 No 1946 If Yes, Give Year or Dates: 1947 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 HS Grad Mechanic Machinery permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic avent 9DGB. 18. Mother's Name (First, Middle, Maiden Sumame) Be John William Scott Ada Blanche Watson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21629 19a. Informant's Name/Relationship (Type, Print) Wife 8886 Watts Creek Lane, Gloria M. Scott Denton, Maryland 20b. Place of Disposition (Name of cemeter, crematory of other place)
Maryland Eastern
Shore Veterans Cem Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4/28/05 * 4 ☐ Donation 5 ☐ Other (Specify) Beulah, Maryland 21. Signature of Funeral Service Ligens 22. Name and Address of Facility
Moore Funeral Home, P.A. 12 South Second Street, Denton, MD 21629 Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Lung Cancer years resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 10 years Examiner Due to (or as a consequence of): death certificate be executed use as the burial-transit that initiated events nding physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery the atten 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown The law requires that the 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Jenknown 1 ☐ Yes 2 ☐ No Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy ormed? 2 X No certificate 1 Tes Hospital or Attending Physicien: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) whe D0051132 4-22-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jorge Abrego, 598 Cynwood Drive, Easton, Maryland 21601 M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 5 Registrar 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 14,2005 Summers Esther Louise 1215 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Preston 21281 Marsh Creek Road Caroline | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | 9. Birthplace (State or Sept. 20, 1940 | Mary land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🖵 F 64 215-38-1983 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Madical Examiner must be natified at Director MD Caroline Preston 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21281 Marsh Creek Road 21655 238 United States Funeral 'neturel', or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Secretarial Administrative Secretary 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertie Sue Collins Harris Elijah Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Summers, Jr./Spouse 21281 Marsh Creek Rd., Preston, MD 21655 20b. Place of Disposition (Name of cometery, crematory or other place)
Bloomery Cem. 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of P
Importent: If Ite
any injury or ot 1 Burial 2 remation 3 Removal from State 04/20/05 Federalsburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate nterval Between Immediate Cause (Final disease or condition setand beath a Physician nsma resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: esn : 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 90 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 2 To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Sign nd title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29466 PINTAIL EASTON, MD 21601 AVID SMITH, M.D DR. SUITE 45, 31. Date filed (Month, Day, Year)
APR 1 32. Registrar's Signature State Registrar

		1- State of Maryland	d / Dep		ealth and M	Mental Hy	Reg. No.2 0 0 5	151.7
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) EMILY B. SHAW 43. Eacility Name (If not institution give street and number)		dh Cit. T	Logation of Danie	2. Date of De	19, 2005 Year	3. Time of Death
Examir Funeral Director	ner	4a. Facility Name (If not institution, give street and number) ANNAPOLIS CONVALESCENT 5. Social Security Number 213 74 2182 6. Sex 1 M 2 TF 7. Age (In yrs. la	Yrs.	ANNAPOLI	If Under 24 Hrs. Hours Min.	8. Date of Bi	ANNE ARUND rth 9. Birthp	EL lace (State or Foreig TAND
In and yearing Z I Z I 2 2000	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, MARYLAND ANNE ARUNDEL 10e. Street and Number 638 RIDGELY AVE. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 07	13.	10f. Zip Code 21401 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No dent's Usual Occupic kind of work done of DO NOT use retired	Specify:		10g. Citizen of What Coun	S an Indian, etc.
d 2 should be file th and Mental Hy 7 is marked oth treumatic event	To Be	17. Father's Name (First, Middle, Last) DANIEL WEBSTER BURTIS 19a. Informant's Name/Relationship (Type, Print)	10h Maili	na Addrage (Stroot o	SARAH PU	JRDY	e, Maiden Sumame) eer, City or Town, State, Zip	Codel
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre any injury or other tre		1 Burial 2 N Cremation 3 D Removal from State	AS CRI	RIDGELY Avantation (Name of matory or other place EMATORY 2. Name and Address 273 SOLOMO ter the mode of dying Amy Illum	o) 04-20 s of Facility GEO NS ISLAN g, such as cardiac	Date 0-05 0RGE P. ID ROAD	AD. 21401 20c. Location - City or To EDGEWATER, MD KALAS FUNERA EDGEWATER, M	L HOME
death certificate be executed be executed be attending physician and burial-transit by for use as the burial-transit by	/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of consequence). Due to (or as a consequence).	ence of):					
that the death cert ed by the attendin detached for use	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	leath 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
The law requires ate has been sign page 2 should be	Completed by P	Part II. Other significant conditions contributing to death but not result Deleta 1a Faulul to Will	ting in the u	nderlying cause give	n in Part I.	1 🗆	an 24b. Were autop prior to comprimed? death?	e cause of death? ably 4 Unknow say findings available pletion of cause of 2 No
for Attending Physicien: Thater death after death Director: After this certificate I in by the funeral director, pag	Certification; To Be		R/Outpatier 28b. Time o Injury	f 28c. Injury Work M 1 🗆 Y	4 Hirising Ho	ome 5 Resi	dence 6 □Other (Specify, how injury occurred Street and Number or Rural	
To the Hospitel or Atterwithin 24 hours after design To the Funerel Directo completely filled in by the	edicai Cer	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	ledge, deat	n occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the	cause(s) and manner as sta	ited. the cause(s)
To the within 2 To the Comple	Med	29b. Signature and title of certifier		29c. License	number 1028		29d. Date signed (Month, E 4-19-05	Day, Year)
Sta Registr	_	30. Name and address of person who completed cause of death (Item 2 AOTT A CHOP2A; MD 600 P2D 31. Date filed (Month, Day, Year) 32. Restar's Signature of APR 2 1 2005	GELY	AVE. #2	31 ANN	APOLIS	, MD 214	a

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apr. 19^{ay} **Physician** Austin A. Summers 2005 11:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Jefferson 5738 Jefferson Pike Frederick 5. Social Security Number 6. Sex Birthplece (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** Year 1911 15√M 2□F 214-10-3011 Yrs. 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other then "natural", or items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examiner must be natilised at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Frederick Frederick 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5738 Jefferson Pike 21703 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) farmer farm owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy A. Summers Julia Harley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Crist (Daughter) 5738 Jefferson Pike, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 4/22/05 Frederick, MD 21. Signature of Funeral Septice Lice Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cadse (Final disease or condition resulting in death) **Physician** Der /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the attending physicien ar hed for use as the burial. Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy certificate 1 Yes 2 No 2X XI To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes ZONo this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Xatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Kertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058726 4/20/05 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 3000D Ventrie Ct., Myersville, MD 21773 Yvette Warren, M. D. 32. Registrar's Signature State Registrar

		1 - For State Registrar	State	of M arylan		artment of tificate o		nd Mental	Hygiei	6000	15480
Physicia	an	1. Decedent's Name (First, Middle	, Last)					Mon	of Death	Day Year	
/Medic	al	Angela Suarez 4a. Facility Name (If not institution	give street and no	ımber)		4h City Town	, or Location of			2005 4c. County of De	1:40 a M
Examin	er	Holy Cross Hos		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Spring	50411		lontgomer	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Day	ar If Under 24	4 Hrs. 8. Date Min. (Mon	of Birth	9.8	irtholace (State or Foreign
Director		None	1 □ M 2 1 F	0	Yrs.	WORTH Day	3	Apri Apri	1 17,	2005 Mai	yland
and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Maryl -f eho	ρ	Maryland Montgo	morv	C 1 1	ver Sp	ring					1 ⊋Yes 2 □ No
r 28a	Director	10e. Street and Number	шегу	011	ver bp.	10f. Zip Code	9		10g.	Citizen of What C	Country?
th witi	al D	3320 Claridge Co	ourt	,		2090)2		Uni	ted Stat	tes
r dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in U orces? 20 No	.S. 13.	Was Decedent of f Yes, specify C	f Hispanic Origi uban, Mexican,	n? (Specify Yes Puerto Rican, et	or No-	14. Race - Arr Black, Wh	
rs afte	by F	12 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 ☐ Yes If Yes, G Year or I	ive		10XYes 2□N	lo Specify:	Bolivia	ın/	Specify: 114	ispanic
2 hou	ted !	15. Deceden	t's Education		16a. Dece	ient's Usuai Occ	cupation	Chilear		o. Kind of Busines	
thin 7:	Completed	(Specify only highes Elementary/Secondary (0-12)	T) (1-4or 5+)	(Give	kind of work dar DO NOT use ret	ne during most o ired)	of working			ŕ
ed wit	Соп	0	0		no	ne	·	·		none	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23e or 28e-1 show sumstic event, the Modical Examinating the routified at	Be	17. Father's Name (First, Middle, Freddy Suarez	Last)					s Name <i>(First, N</i> La Manc i		den Sumame)	
hould d Mer mark matic	P	19a. Informant's Name/Relations	hip (Type Print)		10h Mailir	a Addrage /Stm	1			its as Town State	Zin Code)
d 2 slith an R7 is r		Daniela Mancill								ity or Town, State, ing, MD 2	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. This prince is marked other then "natural", or iteme 23e or 28e-1 ehow eny injury or other traumatic event, the Medical Enarchment ment be notified at once.		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other p	n/aca)	Date	20c.	. Location - City o	r Town, State
Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	-			/21/2005	Reco	ntwood	Maryland
permit. Departn Imports eny inju		21. Signature of Funeral Service	Aigensee /	Mai	22	. Name and Add	dress of Facility	Simple	Tribu	ite, 1040	Rockville
80 5 9 9		(curaya)	(busch-)	wall		Pike, Ro	ckville	e, Maryl	and 2	.0852	
* *		23a. Part1. Enter the sease, or shock, or heart failure. List	complications that only one cause in	caus the deat each line.	h. Do not ent	er the mode of d	lying, such as ca	ardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	_ a. 1	en	ect	VV	M				Oliset and Death
/Medical Examiner			Due to	(or as a conseq	uence of):			\			
	e	Sequentially list conditions, if any, leading to immediate	b. — Due to	(ur as a conseq	uence of).						
cuted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	G								
rate be executed hysician and the burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):						
ate by	dica		d								
The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	hysician/Medical	IF FEMALE:	23c. If yes, or	utcome of pregna	incv					204 Date of 4	
atten f for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta mant at time of d	Ideath 3□	Ectopic pregnal				23d. Date of de Month	eiwery Day Year
t the d by the achec	hysi	1 ☐ Yes 2X TNo 9 ☐ Unknown	9□ Unki	nown							
res that the de signed by the a be detached (by P	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cause	given in Part I.	23e	Did tobacc	co use contribute	to the cause of death?
w require been signald b								_	1 🗌 Yes	2 \ No 3□F	Probably 4 Unknown
e faw re has be	Completed							24a	Was an autopsy	prior to	autopsy findings available completion of cause of
The cate h	Con							10	performed Yes 2 ☑		
ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?				1	34h	of Death (Check	,		
Phys	. To	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	1 3LI DOA	4 LINUIS	7		6 ☐Other (Spenjury occurred	ecify)
ading th. th. : After s funer	tion	1 Natural 5 Pendin 2 Accident investig	g (Mo	nth, Day Year)	Injury	W	lork? □Yes 2□No			11,019 00001100	
Atter octor by the	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 286, Plac	e of Injury - At he ding, etc. (Specif	ome, farm, str	eet, factory, office	æ				Rural Route Number,
rs afte	Cert	4 - 7 - 7 - 7	Duik	aling, etc. (Special	*/			City	or To wn , St	iate)	
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; p	dical	29a. Certifier (Check only one)	g Physician: To th Examiner: On the and ma	e best of my kno basis of examina nner stated.	wledge, death tion and/or in	occurred at the restigation, in m	time, date and y opinion, death	place, and due to occurred at the	to the cause time, date a	e(s) and manner a and place, and du	as stated. se to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifie	EV.	1 ^	-	29c. Lice	ense number		29d. I	Date signed (Mon	nth, Day, Year)
		THU	0,0		1	700	D60844		Apr	cil 20, 2	2005
		30. Name an address of person Alicia D. Odum					lle. MD	20783			
Sta	te	31. Date filed (Month, Day, Year)	2007	Registrar's Signa	ture	elle B		23,03			
Registr		APR 22	Z005 Ke	Registrar's Signa	14/00	To the last of the					

			For State Registrar	State o	f Marylan		artment of F tificate of		Mental Hyg	iene 00	5 5481
			1. Decedent's Name (First, Middle, La	st)					2. Date of Deat	th	3. Time of Death
	Physici /Medic		Joseph Paul Sit	a					April 1	$10^{Day}, 2005^{Y_1}$	04:00 AM
	Examin		4a. Facility Name (If not institution, giv		mber)		4b. City, Town, o	Location of Dea		4c. County of	
			Suburban Hospita	1			Bethesd	a		Montgon	mery County
	Funeral		5. Social Security Number 6. S	Sex	7. Age (In yrs.	ast birthday)	If Under 1 Year	If Under 24 Hrs			Birthplace (State or Foreign Country)
	Director		579-24-1470	IXIM 2□F	78	Yrs.	Months Days	Hours Min	Sep. 6.	Year)	Country) Mashington, D. C
	P .		Usual Residence of Decedent						рерто	1920 W	asiiington, D.C.
	2 hours after death with the Maryland atural; or items 23a or 28e-f show cal Examiner is that be netified at		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Montgo	merv		Chevy	Chase				1 ☐ Yes 2 ☑ No
	th the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	at Country?
	h wil	alD	3601 Jones Bridge	Road			2081	5		II.C.A	
	dea	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13. \	Vas Decedent of H	spanic Origin? (S	Specify Yes or No-		American Indian,
9	after or Ite	Ī	1 ☐ Never Married 2 Married	Armed Fo	2 TNo		Yes, specify Cuba		to Hican, etc.)	Black, \	White, etc.
င္ပ	ral',	by	3 ☐ Widowed 4 ☐ Divorced	Year or D	re 1944-	46	☐ Yes 2万tNo	Specify:		Specify:	White
21215-0036	CI SIL	Completed	15. Decedent's E			16a. Deced	ent's Usuaf Occup	ation		16b. Kind of Busin	
2	d within 73 piene. r than "n.	ple	(Specify only highest gra Elementary/Secondary (0-12)	Colfege (1	1-4or 5+)		kind of work done of OO NOT use retired		nking		
2	e filed within Il Hygiene. other than vent, IL e Ma	Ö	12	00090 (,	Tile	Contract	or		Construc	tion
פ		Be (17. Father's Name (First, Middle, Last)					me (First, Middle, M		CI-OII
<u>a</u>	Mental Mental arked o	To E	John Sita					Marri 1	Elizabeth	D = = 1	
Maryland	2 should be and Mental is marked reumatic ev		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	nd Number or Ri	ural Route Number,	City or Town, Sta	ite, Zip Code)
	alth a		Marie Altimont Si	ta 1	Wife	3601	Ionae Erf	Jan Dan	Ch	C1	1 1 00015
ē,	t Hei f Hei item othe		20a. Method of Disposition		20b. P	tace of Dispo-	sition (Name of place		Date	20c. Location - Cit	ryland 20815 y or Town, State
5	age ent o ent: If y or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		State		teran's Cen	110	ril 26,		
Baltimore,	artme orter injur		21. Signature of Fuheral Service Wee	4	11111	_	Name and Address		2005	rownsvii	le, Maryland
Ba	permit. Pages 1 and 2 should b Department of Health and Mente Importent: If item 27 is marked any injury or other treumatic e once.			/ / /		To be	T	0-111	Funeral 1	Home, Ind	c.
		-	23å. Part1. Enter the disease, or com shock, or heart failure. List only	plications that c	aused the death	501	Univers	ity Blvc	1.,W., Si	lver Spr:	ing MD 20901
			shock, or heart failure. List only	one cause on e	ach line.	/	in the mode of dying	, such as cardia	c or respiratory arre	351,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	HYPOT	herm,	a				Onsor and Death
	/Medical Examiner		Todaking in dodain,	Due to (or as a consequ	ience of):					
i.		_	Sequentially list conditions,	b							
	sit ed	- Pe	if any, leading to immediate cause Frier Underlying Cause (Disease or injury	Due to (or as a consequ	ience of);					
	and I-tran	Examiner	that initiated events resulting in death) Last	C	or as a consequ	10000 of);			·		-
60,	be ey cian buria			00010 (or as a consequ	ience or).					
68760,	ficate be executed physician and s the burial-transit	edical		d						· · · · · · · · · · · · · · · · · · ·	
_			IF FEMALE:	00- 16					-		
Вох	death certif e attending od for use a	lan	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregnal inth 2 - Fetal	death 3	Ectopic pregnancy			23d. Date of Month	f delivery Day Year
	000	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□Unkno	ant at time of de own	ath 5	Other (specify)			Mortui	Day real
P.O.	that fhe de led by the a detached t	F.	Part II. Other significant conditions of	antributing to de	ath hut ant see	dain militaria	4.4.		00 014		
	es ig	Completed by	Hypothyroid	Can	ath but not rest	iiting in the un	derlying cause give	n in Part I.			te to the cause of death?
orc	w requir	ted	471012710101	UPPL					1 🗆 Ye	s 2)(ΩNo 3[Probably 4 Unknown
Vital Records,	has b	ag l							24a. Was an	24b. Were	e autopsy findings available to completion of cause of
<u> </u>	Th ate pag	5							perform	ed? deat	h? Yes 2 No
ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only one	1	
	Physicien: this certific ral director,	2	1 XYes 2 No	Hospital: 1 X II	npatient 2 1	ER/Outpatient	3 DOA Othe	r. 4 ☐ Nursing H	lome 5 🗆 Resider	nce 6 Other (5	Specify)
οl	ding Pt After th funeral		27. Manner of Death	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	w injury occurred	
Division	Attending ir death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investigation	31 1-1 8	4	ununsa	-4-M 1□1	es 2 No	Subject to	appel 1	i, und water
<u>X</u>	or Attendate death Director:	ti ii	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At ho		et, factory, office		28f. Location (Str	eet and Number o	Rural Route Lumber
Ö	s after or selection of Direction	Certification;		ballon	ig, etc. (Specify	Back	yard		Read, Che	SIAIO) 3601	E MD 30315
	Hospitel		29a. Certifier 1 Certifying Ph	ysician: To the	best of my know	vledge, death	occurred at the tim	e, date and place	, and due to the ca	use(s) and manno	r as stated
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	one)	and mann	isis of examinat	ion and/or inv	estigation, in my op	inion, death occu	rred at the time, da	te and place, and	due to the cause(s)
	To the Hospitel within 24 hours a To the Funerel Completely filled	ž	29b. Signature and title of certifier	4	1 2		29c. License	number	29	d. Date signed (M	lonth, Day, Year)
)			170 La-111	las	Ala-		OCM	Œ		April 12	, 2005
	511	1	30. Name and address of person who	completed cause	e of death (Item	23a) (Type, F	Print)				
			MILLICE	Alt	ACI	/		nn Stree	et Balti	more, Mai	ryland 21201
	Sta	te	31. Date filed (Month, Day, Year) APR 2 2 200	2. Re	egistrar's Signat	иге 📗					J
		ar	APR 92 / [III]	J Ha.	17	LA NEW					

			1 - For State Registra VEND#7perFH4/2		laryland / Depa Co <i>Cei</i>	artment of F rtificate of		-	giene 005	15482
	Dharini		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Ellen R. Silvers					Month April	Day Year 19. 2005	11:08 P M
	Examir	ier	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	r Location of Death	n _	4c. County of Dea	
			Hebrew Home of Gre	ater Wash	ington	Rockvill			Montgomer	
м	Funeral Director		5. Social Security Number 6. Social Security Number 1	9X □M 2 X □F 7.A	ge (In yrs. last birthday) 84.85	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da)		rthplace (State or Foreign ountry)
			Usual Residence of Decedent					Nov 24,	1919 Mar	yland
	ylanc		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	DC		Washingto	on				1 ☐ Yes 🏋XNo
	th with th	Funeral Director	10e. Street and Number 3130 Wisconsin Av	e. NW #62	22	10f. Zip Code 20016			10g. Citizen of What C	ountry?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show simportant: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, it a Medical Exercit at marke inclined at once.	Þ	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 1 If Yes, Give 2 Year or Dates:	? No	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 1 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, Wh	
21215-0036	12 should be filed within 72 h h and Mental Hygiene. 7 is markad othar than "natu Iraumatic evant, tre Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	(Give life. I	lent's Usual Occup kind of work done OO NOT use retired	during most of wor		16b. Kind of Business National Symphony O	
	filed Hygie Hygie othar I	ပိ	17. Father's Name (First, Middle, Last)	4	Sale	s	18 Mother's Nam		Maiden Sumame)	Ichestia
Maryland	id be entai kad o ic eve	To Be	Charles Albert Ru	nnerchero	er		Ethel H		walder Surrame/	
ary	shound M	-	19a. Informant's Name/Relationship (7			g Address (Street			or, City or Town, State,	Zip Code)
	and 2		Damon Silvers / S	on	7404	Royal Do	minion D	r. Bethe	sda, MD 20	817
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □		'	natory or other place	1	Date	20c. Location - City o	Town, State
臣	artme artme ortant Injury		 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fundal Service Licen 		Dulaney V			23, 05		, MD
Ba	permi Depa Impo any Ir		* Xin my	Dow	51	30 Wisco	nsin Ave	. NW Was	ler's Sons hington, D	
			23a. Part1. Extenthe disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each I	ine.	/ /	1			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	w	s a consequence of):	cerebra	Vasiula	n dist	ale	
	Examiner		*	h						
	ecuted and transit	Examiner	Sequentially is nonctions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai E	issuming in double, case	Due to (or as	a consequence of):					
9		ledi		v						
.O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
σ,	es that igned b	by PI	Part II. Other significant conditions co	entributing to death t	out not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	the cause of death?
rds	w require been sig should b							1 🗆 Y	es 2 □ No 3 □ P	robably 4 Gunknown
Records,	The law requate has been page 2 shoul	Completed						24a. Was a autop: perfor	sy prior to death?	utopsy findings available completion of cause of
Vital	10 T	BeC	25. Was case referred to medical				26. Place of Dear		2 - N o 1 □ Yes	3
of V	d is	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	3 DOA Othe			ence 6 Other (Spe	cify)
	ing After unel	ation:	27. Mann eath 1 atural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ary 28b. Time of Injury	28c. Injury Work M 1 🗆	at		ow injury occurred	
Division	ospital or Attand hours after death unaral Diractor; , y filled in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	jury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (S. City or Town	treet and Number or R n, State)	ural Route Number,
	I 4 II 0	edicai (29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	rsicien: To the best iner: On the basis o and manner st	of my knowledge, death of examination and/or invated.	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner a late and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	<i>(</i> -		29c. License		2	29d. Date signed (Mont	h, Day, Year)
	L		How & W	ule v	~ 5	253	-258		Baril 20	2005
	7		30. Name and address of person who c	ompleted cause of o	death (Item 23a) (Type, I	Print)				
	in a		Gary B. Wi	1K, on p	6/2/ m	ONTRESE	ROND	RUCKULC	LE MARYL	mn 20152
	Sta Registr	× ×	31. Date filed (Month, Day, Year) APR 2 2 200	15 Status	ars Signature	le le				2005 Amn 20152

90		1 - For State Registrar	State of Ma		artificate of De				
	sician edical	Decedent's Name (First, Middle, Las MARY	Ά.		LIVER		Reg. 2. Date of Death Month	Day Year 28 20	- C 11/T/3 11
Exa	miner	4a. Facility Name (If not institution, give Upper Chesapeake Medi	cal Center		4b. City, Town, or Loc Bel Air		•	4c. County of De	ath ford
Fune Direc		5. Social Security Number 6. Security Number 10. Security Number 1	x 7. Age	7 Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Ye 11/20/19		rthplace (State or Foreign Country) rginia
Maryland -f show	tor	10a. State 10b. County MD Harfor	d	10c. City, Town or L	ocation ceet				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with the Maryland	Funeral Director	10e. Street and Number 3530 Mill Gre	en Road		10f. Zip Code 211	54	10g.	Citizen of What C	Country?
9 E 8	by Funera	11. Marital Status 1 Never Married 2 Married 3 V Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:		Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec	cify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
21215-0036 do within 72 hours all giene.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)	cation	(Giv	edent's Usual Occupation a kind of work done durin DO NOT use retired)	n ng most of working	9	. Kind of Busines	s/Industry
Maryland 2121 Maryland 2121 Maryland 2121 To should be filed within the and Mental Hygiene. To its marked other then it.	To Be Co	Unknown 17. Father's Name (First, Middle, Last) Pete Anderson			Homemaker 18.		(First, Middle, Maid B illi r		
28/05 nore, Maryle ges 1 and 2 should nt of Heelth and Mer stiff then 27 is marke		19a. Informant's Name/Relationship (T) Betty C. Teste		ghter 353(ing Address (Street and I	n Road,	Street, 1	MD 2115	4
Baltimore, permit. Pages 1 an Department of Heel important: If it in a more interpretation of these		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Cremation 5 ☐ Other (Specify,		Fairwood	Cemetery	5/2/2		. Location - City o	Virginia
Ba Permi Depa impo	ouce	21. Signature of Funeral Service Licens Local Months of Funeral Service Licens 23a Part 1. Enter the disease, or comp	welche	Ha	2. Name and Address of rkins Funeral	Home, Inc.		St.,Delta	
Physici /Medio		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. R	r 511		T POKE			Approximate Interval Between Onset and Death
Examin	er j	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last	Due to (or as a	Consequence of):	RO CLE				/
5876(5876) incate be physicia	dicai	Todaling in death) East	Due to (or as a	consequence of):					
O. Box the death cert y the attending other for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
Cords, P wrequires that been signed b	O	Part II. Dther significant conditions co		t not resulting in the u	inderlying cause given in	Part I.	23e. Did tobacc	_	o the cause of death?
of Vital Records, Physician: The law requirest this certificate has been signer and director, page 2 should be a	Q						24a. Was an autopsy performed 1 Yes 24	? prior to death?	utopsy findings available completion of cause of
of Vita Physician: this certifical	To Be	TU Tes 4 No	lospital:		nt 3□ DOA Other: 4		5 Residence		cify)
Vision Attending or death. actor: After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day) 28e. Place of Injury	Year) Injury ry - At home, farm, st	Work? M 1 ☐ Yes		d. Describe how in	and Number or R	ural Route Number,
Div	ical Cert	29a. Certifier Certifying Phy	building, etc. sician: To the best of	f my knowledge, deat	h occurred at the time, da	ate and place, and	d due to the cause	(s) and manner a	s stated.
To the P within 24 To tha P	Medical	29b. Signature and title of certifier	and manner state	ed.	29c. License nun	mber		Date signed (Mont	
4		30. Name and address of person who co		ath (Item 23a) (Type,	Print)		Paus	1011	
9.7	State	31. Date filed (Month, Day, Year) _ MAY 0 6 2	32. Pegistrar	r's Signature	CHURCHVI	BELF	HR "H		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Day Physician Month GRETCHEN RICKEL WOLF 7,2005 APRIL 0157 1 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** BROOKE GROVE REHABILI TATION AND NURSING CENTER MONTGOMERY SPRING SANDY If Under 1 Year If Under 24 Hrs. 8. Date of Birth 0670371913 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Detroit, MI 5. Social Security Number **Funeral** Days Hours Months 1 ☐ M 2 🗓 F 052-07-9249 91 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may joury or other treumatic event, the Medical Evarcinar uses be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** Bethesda MD Montgomery 10e. Street end Number 10f Zin Code 10g. Citizen of What Country? 6901 Barrett LN. 20814 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White δ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Live Theater 4+ Actress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsa Humberg ဥ Armin Rickel 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11443 Rowley Rd., Clarksville, MD 21029 Elsa Barnes / Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 04/20/05 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Comfort Crematory 22. Name and Address of Facility Joseph Gawlers Sons INC. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW, Washington, DC 20016 MO1378 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . CONGESTIVE HEART FAILURE WEEKS Examiner Due to (or as a consequence of): Examiner , CORDNARY ARTERY DISEASE YEARS or Attending Physician: The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, physiciar by Physician/Medical Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPOPROTEINEMIN; ATRIAL FIBRILLATION: funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? RECENT PERLIBNIMS 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred fter death. Director: After to in by the funera 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours

To the Funerel D

completely filled To the Hospital 29a. Certifier (Check only one) 15 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - STARF PHYSICIAN 12046 APRIL 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACE BROOKE HUFFMAN, MD. KIDO SLADE SCHOOL ROAD SANDY SPRING MARYLAND 20860

egistrar's Signature

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) APR 22

		ı	For State Registrer	State of Marylar		artment of H tificate of I			ene 20 (15	15485
	٥.		1. Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death
	Physici		Jeane L. Whitloc	k				April		ear EOS	(50 AM
	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of		
			Hebrew Home of Gr	eater Washing	aton		Rockville		1	Monto	gomery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	. Birthpla	ice (State or Foreign
	Director		577-14-8634 ¹	M 20xF 88	Yrs.	Months Days	Hours Min.	(Month, Day, Oct. 25,		Country nnsy	lvania
	p.		Usual Residence of Decedent								
	show	_	10a. State 10b. County		ty, Town or Lo					100	d. Inside City Limits
	Ba-1:	cto	Maryland Prince (George's	Colle	ge Park					1 ☐ Yes 2 № No
	ith th	Director	10e. Street and Number		0.0	10f. Zip Code	4.0	10	g. Citizen of Wha	at Countr	y?
	23a	rai	9314 Cherry Hill	-		207			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinate multiple at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🏞 No	ispanic Origin? (Spi in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White, et	ic.
-	72 ho	ted	15. Decedent's Educ (Specify only highest grade		16a. Deced	ient's Usual Occup	ation during most of work	ina	6b. Kind of Busin	ness/Indu	stry
2	thin thin	Jple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	i)	9			
	gd wil	Completed	12		Home	emaker			Own	n Hor	ne
2	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	faiden Sumame)		
<u>a</u>	uld b Ment arked	0	John Rader				Sadie	Conkey			
Maryland	2 sho and I		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	ng Address (Street	an <i>d Number or Rur</i> a	al Route Number,	City or Town, St	ate, Zip C	ode)
	and salth		McDonald Whitlock	·			Mill Roa	d, Wheat	on, MD	20902	2
Sre	S = 2 = 3		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ R		Place of Dispo cemetery, cren	sition (Name of natory or other place		1 21,	Oc. Location - Ci	ty or Tow	n, State
Ĕ	Pagenent Int: I		'4 □Donation 5 □Other (Specify)	Met	ropolita	n Cremator	200		lexandr	ia, V	Virginia
Baltimore,	permit. Departr Imports any inju		21. Signatur, Ti Funeral Service License	cerlo	F1 50	Name and Address ancis J. O Univer	sity Blvd	Funeral , W, Sil	Home Inc. ver Spr	ing,	MD 20901
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	1	Approximate Interval Between
	Pnysician	١,	Immediate Cause (Final	1.7	المساء	h	a visco Wi	and a	1		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec		10 00	Whio vas	aujar	arso	010	
	Examiner										
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):						
	cuted d ansit	Examiner	Cause (Disease or injury that initiated events								
o,	exection and and and and and and and and and an		resulting in death) Last	Due to (or as a consec	quence of):						
8760,	cate be executed physician and the burial-transit	dicai									
9	20 8	led					-77				
Box	that the death certific ed by the attending F detached for use as	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of		
	0 0 2	icia	in the past 12 months?	4 Pregnant at time of e		Other (specify)			Month		Day Year
0.	t the by th tache	hys	9 🗌 Unknown	9LI OTKIDWII							
	The law requires that the tte has been signed by thoage 2 should be detache	by F	Part II. Other significant conditions con	tributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	ute to the	cause of death?
p	w require been si should I							1 □ Ye	s 2□No 3	☐ Probal	bly 4 Unknown
Vital Records,	aw requisibeen	ompleted						24a. Was ar autops	24b. We	re autops	sy findings available pletion of cause of
ž	The lavate has	E						perform	red? dea	th? Yes 2	
ā		e C	25. Was case referred to medical				26. Place of Deat				
\geq	S S	O B	examiner?	ospital:	ER/Outpatien	nt 3 DOA Oth	er: 4 Nursing Ho	me 5 Reside	nce 6 Other	(Specify)	
0		J.:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		y at	28d. Describe ho	w injury occurred		
0	Attending r death. ector: After by the fune	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Wollan, Day You)	Injury		Yes 2 □ No				
Division	or Attenoafter death	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	nome, farm, str	eet, factory, office		28f. Location (Str City or Town		or Rural	Route Number,
ō	spital or A ours after seral Dire	Cert		building, etc. (Speci	·· j/)			ony or rown	, Jiaioj		
	Hos Hun Hos Wely	edical ((Check only 2 Medical Examination one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ite and place, and	d due to t	the cause(s)
	To the I within 2 To the I complet	Be	29b. Signature and title of certifier	11		29c. Licens	e number	29	d. Date signed (Month, D	ay, Year)
£	1 - 0		Jonsuel /	Ulvacy		D:	44907		Amil	21	2005
	>		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type.	Print)	USU51.	11-00	-0F 2- 1	wo 1)
			30. Name and address of person who co	wie Road	1 /2	OCKVILL	C MIN	7 7 200	8572	-	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	10	- 000				
	Regist		TOR 2 2 2005	Kendye &	6084						

Whitbock, Jeane

December Name First Messel, Last 2 2 2 2 2 2 2 2 2			For State	State		and / Dep		t of H	ealth a	and M	lental Hyg	iene) 0.5	Ora	.86
Lawrence James Wolsh April 18, 200 Year 2:00 Account of Cearling Account Account of Cearling Account Accou			Registrar 1. Decedent's Name (First, Middle	e. Last)			Timoati	01 2	Jeann				()	3 Time of	Death
As Somethy Manual Properties and Pro											Month	Day			рм
24.00 Dennis Avenue Silver Spring Montpole 7.10-09-6411 Maryland 8.30 Vs. Morning Spring Spring Spring Montpole 7.10-09-6411 Maryland Nongress Non					umher)		4h Cihi	Town or	Location	of Dooth	April 1	T		2:00	
Second Second Processor Topic Company To	Examin	er			uor/		1				_	40. 000			
The property of the property o	Francis				7. Age (In v	rs. last birthday									
Use A Personal Processor Documents D											(Month, Day	Year)			i, roieigii
20. Almost of Deposition Sequential Sequ			Usual Residence of Decedent								000. 30	, 1921	Mar	yrand	
20. Almost of Deposition Sequential Sequ	ylan		10a. State 10b. County		10c.	City, Town or L	ocation							IOd. Inside Ci	ity Limits
20. Almost of Deposition Sequential Sequ	Ma - Ma	tor	Maryland	Montgome	ry	S	ilver	Spr	ing					1 🗌 Yes	2X No
20. Almost of Deposition Sequential Sequ	th the	ire	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cou	ntry?	
20. Almost of Deposition Sequential Sequ	15 will 15 wil	aic	2408 Dennis A	Avenue					20	902			USA		
20. Almost of Deposition Sequential Sequ	dea	ner	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Deced	lent of Hi	ispanic Ori	igin? (Spe	ecity Yes or No-				
20. Almost of Deposition Sequential Sequ	S age of a	E.		ned 1 X Yes	2 🗆 No						r nouri, oto.,				
20. Almost of Deposition Sequential Sequ	ours I En		3 Widowed 4 Divorced			VII		- 99	-p-00y.			Spe	WIII:	Le	
20. Almost of Deposition Sequential Sequ	72 r	ete	15. Deceden (Specify only highe	t's Education st grade completed	1)	(Giv	e kind of wor	k done o	during mos	t of work	ing	16b. Kind o	f Business/In	dustry	
20. Almost of Deposition Sequential Sequ	withir he	E D		College	(1-4or 5+)									ply	
20. Almost of Deposition Sequential Sequ	iled v			l act)	<u>.</u>	Ma	nager/	Sale		*	Cient Middle				
20. Almost of Deposition Sequential Sequ	al be f and be d ad of	Be		•							,		тате)		
20. Almost of Deposition Sequential Sequ	y hould d Me nark natio	P				10h Mai	liam Address	(Ctropt o					- 01-1- 7	0.41	
20. Almost of Deposition Sequential Sequ	VICEUR														
Agental 2 Greated for Stock of Parl 2 Commander of State Methodist Church 2005 Laurel, Maryland Agental 2 Commander of Stock of Parl 2 Signature of Funeral Service Leansee Farl 2 Signature of Funeral	D			sn/ wire		2408 Place of Disc	Denni	LS Av	venue	, Si					
Physician /Medical Examinor Physician /Medic	S S S S S S S S S S S S S S S S S S S		1 ☐ Burial 2 ☐ Cremation		II State				ì	Apri	1 23,	200. LUGATIC	or - City or 10	JWII, State	
Physician /Medical Examinor Physician /Medic	t. Pa				Em				1	-				land	
Physician /Medical Examinor Physician /Medic	Deparenti Deparenti mpoorni nny ir		21. Signature of Funeral Service	Licensee		F	2. Name an rancis	d Addres	coll	ins	Funeral	Home	Inc	100000000000000000000000000000000000000	NAME OF THE PARTY.
Physician Medical Examiner Ph	4 40260		J. Ken Stile										pring,		
Physician Medical Examinor Sequencially list conditions of lists as a consequence of):	256.5		shock, or heart failure. List	only one cause on	each line.	eath. Do not er	nter the mod	e of dyin	g, such as	cardiac o	or respiratory arr	est,		Approximat Interval Bet	ween
Due to (or as a consequence of): Sequentially ist conditions, if any, leading to immediate gause. Enter Underlying that included events or resulting in death) Last Due to (or as a consequence of): Due to (or as consequence of): Due to (or as a consequence of): Due to (or a			disease or condition	_ a Mye	loproli	iferati	ve Dis	orde	er						
Bequentially list conditions far any leading to immediate gause. Enter Underlying cause gave. Enter Underlying cause. ause. Enter Underlying cause cause. Enter Underlying Cause cause. Enter Underlying cause cause. En			resulting in death)	Due to	o (or as a cons	equence of):									
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of preserved on the consequence of): Due to (or as a co	Examino	L	Sequentially list conditions,	b. —											
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of preserved on the consequence of): Due to (or as a co	si ed	ine	rt any, leading to immediate cause. Enter Underlying	d Due to	o (or as a cons	equence or):									
Section Sect	and I-tran	хап	that initiated events resulting in death) Last	c.	o (or as a cons	equence of):			_						
FFEMALE: 23d. Date of delivery 23d. Date of deli	be ey be ey ician burla	ie E			0 (0: 00 0 00:10	34451100 017.									
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	2 2 2 2			d.											
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	Se as	/Me		23c If yes o	utcome of pre	nancy									
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	atten for u	ian	in the past 12 months?	1 ☐ Live	birth 2 🗆 F	etal death 3								,	Year
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	b e d bed	ysic				i dealii 5	□ Other (sp	өспу)							
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	that the ed by detain		Part II. Other significant condition	ons contributing to	death but not	resulting in the	underlyina c	ause give	en in Part I		23e. Did tol	pacco use c	ontribute to t	ne cause of d	eath?
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	sign d be						, ,								
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	been phone	ete							•		-				
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	has has	п									autops	y	prior to co	psy findings mpletion of c	available ause of
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	icate						_						1 Yes	2 🗆 No	
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	icier icertif ector	00	examiner?	Hospital:				Oth				-/			-
12 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Rural Route Number	Phys this	-		1				A Cure	4 □ Nu					y)	
28f. Location (Street and Number or Rural Route Number of Rural Ro	ling After	ion	1x Natural 5 ☐ Pendir	ng (Mo	onth, Day Year) Injury					28a. Describe no	w injury oci	curred		
296. Signature and till at certifier D31563 April 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, M.D. 10801 Lockwood Drive, #205, Silver Spring, MD 2090	ttend death ttor:	icat	3 ☐ Suicide 6 ☐ Could	not be	no of laive. A	hama farm a			105 2	-	29f Looption (C	read and Air		10-1-1	
296. Signature and till at certifier D31563 April 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, M.D. 10801 Lockwood Drive, #205, Silver Spring, MD 2090	or A after Direction by	erti	4 ☐ Homicide determ	nined 200. Flat	ding, etc. (Spe	ecify)	treet, ractory	, once					iniber or mura	u Moute Num	ber,
296. Signature and till at certifier D31563 April 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, M.D. 10801 Lockwood Drive, #205, Silver Spring, MD 2090	pitel purs a		29a Certifier 1/X Certifier	a Physician: To the	no hoot of my	raculadas das	the constraint	- 4 Ab - 4		d -lasa		- 4) - 4			
296. Signature and till at certifier D31563 April 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, M.D. 10801 Lockwood Drive, #205, Silver Spring, MD 2090	Hos 24 hc Fun stely	dica	Check only 2 Medical	examiner: On the	basis of exam	ination and/or i	nvestigation,	in my op	pinion, dea	ith occurr	and due to the cared at the time, d	ause(s) and ate and plac	manner as s æ, and due te	tated. o the cause(s)
D31563 April 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, M.D. 10801 Lockwood Drive, #205, Silver Spring, MD 2090	o the o the	Me	A .		>		290	. License	e number		2	9d. Date sic	ned (Month.	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, M.D. 10801 Lockwood Drive, #205, Silver Spring, MD 2090	⊢≯⊢ŏ		> // \ \ (ille 1	2			D31	.563			_			
Charles M. Benner, M.D. 10801 Lockwood Drive, #205, Silver Spring, MD 2090	4+1		30. Name and address of parage	who completed as	Use of death /	tem 22a) /Tues	Drine)								
	,						,	Dri	Ve -	#205	Sil	Cnmi	n	20001	
TOTAL OF THE LEVEL AND MARKET	Sta	ite	31 Date filed (Month, Day, Year)					211	ve, 1	m 200,	PIIVEL	spr1	irg, MD	20901	·
State Registrar APR 2 2 2005 Registrar's Signature			APR 22	2005	due 1	S. April	wee								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 14 per FH G843 05/19/05dhb

Amend Item 23a,28b,d,f per me G843 5-18-05 tas

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 0940 6 DECCO pr 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner 346 Spring montromes Silver International If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Nov. 5, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Days 1914 1□ M 2√ F 90 Pennsylvania Director 165-07-4177 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rthan "netural", or items 23a or 28a-f sho the Medical Examiner must be nutflied at t∳ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3701 International Drive, Apt. 346 20906 U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24⊡ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc White filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: U. S. A. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important; if teen 27 is marked other th
eny highry or other treumatic event, m
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Spivak Hannah Glick 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jerome A. Ziskind -509 Northwest Street, Falls Church, Virginia 22046 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State National Crematory 4/21/2005 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between 23a. Part1. Enter the disease, or complications that caused the description shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner DO XIQ Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hor δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No TITYUS 21 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) ٩ 1A Yes 2 □ No 28b. Time of Injury Found Injury at Work?

1 Yes 22No subject placed plastic bag over her head 27. Manner of Death 28e. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 Natural 14 20000925 within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu 2 Accident 28t. Location (Street and Number or Rural Route Number.) Dr #36th or Town, State) 370/ Information Dr 5/Ver Sprins MD 6 Could not be Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide HAME To the Hospitel
within 24 hours 6 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Si maure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) w my Dmis 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER, mo DME 31. Date filed (Month, Day, Year) Registrar's Signature State 2 2 2005

Registrar

		State of Maryland 1- State Unpend Item 23a,27,28a-f per	/ Depa	irtment of H 1843 5-19 Illicate of 1	ealth and 5eath as	Mental Hygi	ene g. No. 005	1548
Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day You	3. Time of Dea
/Medic		Titus Tyrone Aye, Sr.				May 3	, 2005	2:45 P
Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		th	4c. County of De	
		1013 Brockton Court 5. Social Security Number 6. Sex 7. Age (In yrs. las.	t de Ceste etc ()	Glen Bu	rnie	Date of Bigh	Anne A	
Funeral Director		215-68-4283 15 M 2 F 48	Yrs.	Months Days	Hours Min		Year) 9. E	lirthplace (State or Fo Country)
		Usual Residence of Decedent				July 11	1956 M	<u> </u>
how		10a. State 10b. County 10c. City, 1						10d. Inside City L
S-F	cto	MD Anne Arundel G	Len B	urnie				1 ☐ Yes 2
or 28		10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
s 23a	ra	1013 Brockton Court			21060		U.S	
t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinator and burnalities at	by Funeral Director	11. Marital Status 1 Never Married	.	Vas Decedent of His Yes, specify Cubar		Specify Yes or No- rto Rican, etc.)	Black, Wi	nerican Indian, nite, etc. Black
atura cal E	ted	15. Decedent's Education	6a. Deced	ent's Usual Occupa	ition	1	6b. Kind of Busines	
. E E	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done d OO NOT use retired)	uring most of wo	orking		,
giene er th	mo.	2	Iron	Worker			Local	16
al Hy d oth	Be (17. Father's Name (First, Middle, Last)				me (First, Middle, M	aiden Sumame)	
and Mental Hygiene. Is marked other than aumatic event, the Mi	To	WT Aye				e Taylor		
ls m						ural Route Number,		
tealth om 27 her to		Mr. W T Aye / son				Glen Bur		21060
or of the		TEX DOTAL E CONTINUES OF CONTINUES OF CONTINUES		sition (Name of natory or other place	1		0c. Location - City	
rtmer rtant njury		*4 Donation 5 Other (Specify) Mary 21. Signature of Aneral Service Licenses				11,2005		-
Department of Health a Important; if item 27 is any Injury or other tra once.		WII I WIN				ingleton F .W., Glen		
		23a. Part1. Enter the disease, or complications that caused the death.	-					Approximate
physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Inter Underlying Cause Interest of hur that initiated events resulting in death) Last Due to (or as a consequent of the						
by the attending tached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3□ n 5□	Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
been signed should be de	by	Part II. Other significant conditions contributing to death but not resulting	ig in the ur	derlying cause give	n in Part I.	23e. Did toba	. /	to the cause of death Probably 4 □Unkr
ate has page 2	Completed					24a. Was an autopsy performe 1 Yes 2	24b. Were prior to death?	autopsy findings avai o completion of cause es 2 \(\text{No} \)
centif	o Be	25. Was case referred to medical examiner?		Otho		ath (Check only one)		
r this aral di	-	27. Manner of Death 28a. Date of Injury 28	Outpatient b. Time of	3 DOX	4 Nursing r	Home 5 Residen		-
th. : After s funer	tlor		Jaiury	28c. Injury Work P ^M 1 □ Y	? es 2. <mark>⊋</mark> No		many occurred	unk
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 M Could not be determined 28e. Place of Injury · At home building, etc. (Specify) Found at home			Α	28f. Location (Stre City or Town, Glen Burn		Rural Route Number
within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle and manner stated.	dge, death and/or inv	occurred at the time estigation, in my opi	e, date and place inion, death occu	and due to the cau	se(s) and manner	as stated. ue to the cause(s)
withir To th comp	Me	29b. Signature and title of certifier		29c. License	number		I. Date signed (Mor	
		30. Name and address of person who completed cause of death (Item 23	W)	OCME		M	ay 7, 200	95
		So, maine and address of person who completed cause of death (Item 23	a/(Iype, l	rurit)				
		MAMANIM A ILMEN		111 P	enn Stre	eet Balti	more. Ma	ryland 212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar amend item #2 per phy g843 5/97/1/69 tem f Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04 3 Time of Death **Physician** ICHARD JEROME MAI n, or Location of Deau.

ALTIMORE
ear If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
OCT: 29,1919 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ESWICK MULTICARE ENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months 160 M 2 F 31-01-378 5 Yrs. Director MAR Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "neturel", or Items 23a or 28e-f show other treumatic event, the Madical Exertile at must be notified at 1 Yes 2 □ No Director MARJILAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENUE AWFORD USA: Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than any injury or other treumatic event, If a Marans injury or other treumatic event, If a Marans Elementary/Secondary (0-12) College (1-4or 5+) BALTO CITYPUBLIC SCHOOLS (MASTERS DEGATE EDUCATOR - MATH TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BROWN 2 TAMES RIBNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 CRAWFORD BALTIMORE INDA Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State EMETERY 05-10 4 ☐ Donation 5 ☐ Other (Specify) -05 BALTIMORE, MARYLAND 22. Name and Address of Facility BROWN INSTEAD AVE. 21. Signature of Funeral Service Licenses JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physiclen and s the burial-transit Due to (or as a consequence of): Physician/Medical use as tF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Þ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records. 1 Yes 2€ No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an hasl page 2 1 Yes 2 No 2 No 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 PNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 3 🗀 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Tertifying Physicient To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical completely 29b. Signature and title of contrier 29d. Date signed (Month, Day, Year) 22 33

Registrar

State

31. Date filed (Month, Day, Year)

MAY 0 9

2005

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Pamela Jean Boyd 05-03138 RPD

	1 - For State Registrar		partment of Health and I Pertificate of Death	Mental Hygien Reg. พ	$ \sim$ \cup \cup \cup	1549
Physician /Medical	1. Decedent's Name (First, Middle, La Pame1a Jean B	oyd		2. Date of Death Month May 6, 20	ay Year	3. Time of Death 0650 A
Examiner	4a. Facility Name (If not institution, giv 751 Johaha Drive	e street and number)	4b. City, Town, or Location of Death Westminister	C	c. County of Death Carroll	
Funeral Director	220 00 0771	ex ☐ M 2X F 7. Age (In yrs. last birthda 41 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year Dec 23 190	r) 9. Birthpl Count 63 Md	ace (State or Foreig try)
f show	Usual Residence of Decedent 10a. State 10b. County Md Carrol1	10c. City, Town or Westmi			10	0d. Inside City Limit
3a or 28a at the multi-	10e. Street and Number 751 Johahn Drive		10f. Zip Code 21158	1	itizen of What Count	try?
permit. Pages 1 and 2 should be lided within 72 hours arier death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If liem Z7 la merked other than "natural", or Itlams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be multified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Nøver Marriød 2 □ Marriød 3 □ Widowed 4 ▓ Divorcød	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, a Specify: Whit	etc.
d within 72 inglene. Bir than "natur, the Wedical.	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ide completed) (Gi	cedent's Usual Occupation we kind of work done during most of wor . DO NOT use retired) etaker	king	Kind of Business/Ind	ustry
Mental Hy Mental Hy arked othe atic event	17. Father's Name (First, Middle, Last William Triplett	Bassler	Catheri	ne (First, Middle, Maide ne Irene G	reen	
l and c sin	19a. Informant's Name/Relationship (Wendy Walters (da 20a. Method of Disposition	ughter) 190	iling Address (Street and Number or Ru Alymer Ct., Westm	inster, Md		
if. Fages attment of hortant: If ite niury or of	1 ☐XBurial 2 ☐ Cremation 3 ☐ 1 ☐ YBurial 2 ☐ Cremation 3 ☐ 1 ☐ Other (Special Service Lice	Evergre	position (Name of emaiory or other place) een Memorial 5-10- 22. Name and Address of Facility Haj	-05 Fin	ksburg,Md	
Depar Impor	Dage Haigh		.O. Box 195 Sykesy	ville, Md 2		Approximate
cate be executed physician and physician and the burial-transit sthe burial-transit calcal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		nsdentic cardiova	rsinian di	Sease	Onset and Death
death certification of for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	ry Day Y <i>e</i> ar
requires that the een signed by the rould be detache red by Phys	Part II. Other significant conditions Dinbetes Melli	contributing to death but not resulting in the	underlying cause given in Part I.		ouse contribute to the	ably 4 Unknow
: The law r cate has be ; page 2 sh Comple				24a. Was an autopsy performed?	death?	osy findings availat apletion of cause of 2 No
ding Physician: The h. After this certificate funeral director, pag	examiner? 1X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpat 28a. Date of Injury (Month, Day Year) 28b. Time Injur	ient 3 DOA Other: 4 Nursing H	ath (Check only one) lome 5 \subseteq Residence 28d. Describe how inj		at scene
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification;	1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not t 4 Homicide determined	θ 39a Place of Injury. At home form	M 1 ☐ Yes 2 ☐ No	28f. Location (Street a City or Town, Sta		Route Number,
To the Hospita within 24 hours To the Funeral completely fille Medical C	29a. Certifier 1☐ Certifying P (Check only one) Medical Exa	nysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.				
To th comp	29b. Signature and title of certifier	i, mid	29c. License number OCME		Pate signed (Month, L	Day, Year)
-1	30. Name and address of person who	completed cause of death (Item 23a) (Typ	e, Print)	Baltimore		

					State of	Maryland	•	artment of t tificate of	Health and I Death	wentai ny	/gierie Reg. No. 👸	ri lib.		
			1. Decedent's Name (First	st, Middle, Le	st)					2. Date of D Month	eath 🛴	0,05	3. Time of Death	
	Physici /Media		Ruth G.	Billon	e					April	16, 200	Year 5	9:15 AM	
	Examir		4e. Fecility Name (If not is		street and numb sing Cen				4b. City, Town, or I		,			
			5. Social Security Number			Age (In yrs. la	et hirthday)	If Under 1 Year	Silver S			ntgom		
	Funeral Director		132-05-0167 Usual Residence of Dece	1	□M 2 1 F	84	Yrs.	Months Days		(Month, D	ay, Year)), 1920		ace (State or Foreign try) y land	
	land			County		10c. City,	Town or Lo	cation				10	Od. Inside City Limits	
	Mary e-f sh	tor	MD M	lontgom	ery	S	ilver	Spring					1 □ Yes 27 No	
	or 284)irec	10e. Street end Number					10f. Zip Code			10g. Citizen of	What Coun	try?	
	ath w	ral	1400 Fenwi	ck Lan					20910			SA		
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be neithed at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 3 ☒ Widowed 4 ☐ □		12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	Ø No es:	1	I□Yes 2∭No			o- 14. Rac Blac Specifi	ce - America ck, White, e v: wh		
5-0	72 h	etec	15. D (Specify on	ecedent's Ed ly highest gra	ucation de completed)		16a. Deced (Give	lent's Usual Occu kind of work done	pation during most of wor ed)	king	16b. Kind of B	usiness/Ind	ustry	
121	within ane. then	Be Completed	Elementary/Secondary	(0-12)	College (1-4	or 5+)	life. L	cashier cash			superma	rkata		
d 2	filed v Hygie ther i	ပို	17. Father's Neme (First,	Middle, Last)				cabhici		ne (First, Middle	e, Maiden Suman			
lan	lid be lental kad o ic eve	To B	Louis Kump	e1					Frances Potenza					
ary	s mar	-	19a. Informant's Name/R				19b. Mailin	g Address (Stree	t end Number or Ru	rel Route Numb	ber, City or Town,	State, Zip	Code)	
	and 2	ģ.	Thomas Bill	one/so	n				Mill Dr	ive Cen	7		20120	
Baltimore,	Pages 1 nent of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre 4 ☒ Donation 5 ☐ C	mation 3 🗆		COL	netery, crem	sition (<i>Nam</i> e of natory or other ple	ece)	Date	20c. Location -	City or To	vn, State	
Balt	permit. Departimonts any inj		21. Signature of Euneral Rona	21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatom Baltimore, M							. Baltim	nore S	treet	
			28a. Part1. Enter the dis- shock, or heart failu	ease, or comp	olications that cau	sed the death.	Do not ente	er the mode of dy	MD 212 ing, such es cardiac	or respiretory	errest,		Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	,		ONIC (RUCTI	IE PUL			ASE	Onset and Death VEARS	
	ed sit	lue		_	b									
, 0,	e executa ian end uniel-tren	Exan	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	ns, ate		Due to (or e	es e consequ	uence of):				1		
68760,	rificate be executed ng physician end es the bunel-trensit	Medica	that intraled events resulting in death) Last	1	C	Due to (or a	is a consequ	uence of).		-		Ī		
Box	th cer tendir r use	an			d							1		
_	e dea the et ned fo	SICI	Part II. Other elgnificent	conditione co	ontributing to deat	h but not result	ing in the un	ndertying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?	
s, P.O.	requires thet the death cer neen signed by the ettendir hould be deteched for use	y Phy	CORONA	RY A	RTERY					1)×	Yes 2□No	3 ☐ Prob	ably 4 🗆 Unknown	
Records,	_ 00	Completed by Physician/Medical Examiner	CON GLES	TÎVE	HE	ART	P	AILVK	F		s an autopsy ormed?	ava	re autopsy findings ilable prior to ipietion of cause eath?	
æ	The la ete he page 3	mo	DIABET	TES	MELLI	TUS	•			10	Yes 2 No	1 🗆	Yes Ž Z No	
/ita	ilen:	Be	25. Was case referred to examiner?	medical					26. Place of Dea	th (Check only	one)			
<u>></u>	Physicien: r this certific aral director,		1□ Yes 2⊅No			atient 2 E	THE RESERVE	I SLI DUA			idence 6 □Oth			
Division of Vital	Ing P	ö		Pending	28e. Date of I (Month,	Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2 □ No	28d. Describe	how injury occurr	red		
isi	Attending or death. ector: After by the fune	ficat	2 Accident 3 Suicide 6 □	investigation Could not be		Injury - At hom	ne. farm. stre	et, factory, office		28f. Location (Street and Numb	er or Rural	Route Number.	
<u>≥</u>	lor A effer Direct	ert	4 ☐ Homicide	determined		, etc. (Specify)		,,,			wn, State)			
_	To the Hospital or Attending Physicien: The law within 24 hours effect death. To the Funerel Director: After this certificete hes i completely filled in by the funeral director, page 2	edical Certification: To	29a. Certifier (Check only one)	Certifying Phy ledical Exem	rsician: To the be Iner: On the basi and manner	s of examination	edge, death on and/or inv	occurred et the ti estigation, in my	me, date end place, opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	inner as sta and due to	ited. the cause(s)	
	To the To the comp	Me	29b. Signature and title of	certifier	1000		-	29c. Licen	4		29d. Date signer	d (Month, D	ay, Year)	
			L. A.	<u>_el</u>	W			D4-	2403		4-1	7-0	25	
			30. Name and eddress of IRAT MAT	person who	complete cause	of death (Item 2	23e) (Type, F	Print) TREET	WASH	HNATO	N DO	20	010	
	Sta	te	31. Date filed (Month, Day		2. Reg	istrar's Signatu	TO Annual	16.3						
	Registr	ar	MAY 0	9 2005	Alle	JA.	July 1							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ... 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Month April 27, Physician Pete Andrew Blauciak 2:30 PM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1067 Church Street Baltimore 8. Date of Birth
June 29, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year 1917 **Funeral** Days Hours Min. 1 X M 2 □ F Maryland 87 217-07-2643 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow injury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No **Funeral Director** Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1067 Church Street 21225 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 42-46 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify white Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coltege (1-4or 5+) it of Health and Mental Hygiene. Elementary/Secondary (0-12) sheet metal mechanic construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be Andrew Blauciak Helen Jaworski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Leah Blauciak/spouse 1067 Church Street Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H important: If ite any injury or ot 1 ☐ Buriaf 2 ☐ Cremation 3 ☐ Removal from State

4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 32 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 nour Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Cino Ma (9) **Physician** 125 on e monTh disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? , page 2 certificate has autopsy performed 2 No 1 Tyes 2 No 1 Yes Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ☑Naturaf 5 Pending 1 ☐ Yes 2 ☐ No М death. 2 Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral E 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). 31. Date filed (Month, Day, Year) State MAY 0 9 Registrar

			1 - For State Registrar	State of M	laryland /		artment tificate			and M		Reg. No.	200	5	1549
	Physici /Medic		Decedent's Name (First, Middle, William M		Burton,	Jr.					2. Date of De Month	Day	Ye. 200		3. Time of Death \
	Examir		4a. Facility Name (If not institution, Saint Josep	h Medical	Cent					OWS (lt	imore
İ	Funeral Director		5. Social Security Number 215–34–5802 Usual Residence of Decedent	5. Sex 7. A 1 M 2 □ F	ge (In yrs. last	birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da August 1	7, 19	9. 37 Ma	Birthpla Count aryla	ace (State or Foreign lry) and
	ne Maryland 8a-f show Aiffied at	ctor	10a. State 10b. County MD Balt	imore	10c. City, T	OWSOI	ר							1	0d. Inside City Limits 1 ☐ Yes 2√ No
	ath with the 23e or 2	rai Dire	10e. Street and Number 1126 Gypsy La					21286				U.	en of What S.A.		
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any injury or other traumatic event. I'm Medical Era cit at martle rotified at 2006.	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Deceden Armed Forces d 1 Tyes 2 Tyes, Give Year or Dates	? KNO		Was Decedon fYes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		4. Race - A Black, W Specify:	/hite, e	
Maryland 21215-0036	d within 72 h giene. or than "netu	ompietec	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or		(Give life.	tent's Usua. kind of wor DO NOT us 1scape	k done di e retired)	urina mosi	t of worki	ing		d of Busine ndsca		•
land	ld be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, La		Burton,	Sr.					(First, Middle	, Maiden S	Витате)		
Mar	and 2 shou alth and M 127 Is mar er traumati		19a. Informant's Name/Relationshi	p (Type, Print)	1	19b. Mailir	g Address Gypsy				al Route Numb	er, <i>City</i> or 21 286	Town, Stat	'e, <i>Zip</i> (Code)
Baltimore,	Pages 1 at the thent of He tent: If item		20a. Method of Disposition 1 Burial 2 CCremation 3 4 Donation 5 Other (Special Service)	ecity)	ceme	etery, crer p Serv	sition (Nam natory or ot vice Co	rpora	tion 5	5/11/0	oate 05 k Towson	Tau	ation - City	'n.	
8760,	Physician /Medical Examiner	edical Examiner	23a. Part 1. Enter the disease, or c shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a	ed the death. D	Do not ent Ce of):	er the mode	k Rd.	, Tow , such as	son,	MD 2120	4			Approximate Interval Between Onset and Death
.O. Box 6	the death certific y the attending p ached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	_	e of pregnancy 2 Fetal de at time of death	ath 3□	Ectopic pre Other (spe					23	3d. Date of Month		y Day Year
Records, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant condition	s contributing to death	but not resultin	ng in the u	nderlying ca	use give	n in Part I.						e cause of death?
	sicien: The law r certificate has be lirector, page 2 sh	Completed									24a. Was auto perio 1 Yes		24b. Were prior death	to com	sy findings available apletion of cause of No
Division of Vital	or Attending Phy ifter death. Director: After this in by the funeral d	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin	ot be 28e. Place of Ir	ury 28 ay Year)	Outpatier b. Time of Injury	28 M	3c. Injury Work' 1 □ Y	r: 4□ Nu	rsing Hor	me 5 Resi 28d. Describe 28f. Location (City or Tot	dence 6 how injury Street and	occurred		Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	of examination	dge, deati and/or in	n occurred a vestigation,	at the time in my opi	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner place, and e	r as sta due to t	ted. the cause(s)
)	To the within 7 To the comple	W	29b. Signature and title of certifier 30. Name and address of person w	tho completed cause of	death (Item 23	la) (Type		License D3Ø3					signed (M		
DH	Sta Registi	rar						TOV	VSON.	, Mf	RYLAN	D 21	204		

			State of Maryland / Dep		Mental Hygi	iene	1 part on a
			Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of Death	g. No. Z	3. Time of Death
	Physicia		John Searles Boulden, Jr.		Month	05 Yeer 200	0 10 0
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	-
	- Zamini	Ο.	8505 Westford Road	Lutherville		Baltimore	9
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 215 - 30 - 7911 12 M M 2□ F 75 Yrs	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		9. Bir	thplace (State or Foreign ountry)
	Director		213 30 7311		Dec. 9,	1929 Unio) "'
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary -f sh	to	MD Baltimore Luthervil	le			1 ☐ Yes 2 💢 No
	r 28a	irec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What C	ountry?
	th wit	Funeral Director	8505 Westford Road	21093	U	SA	
	r dea	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerlo	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
ဝ	s afte	Ьу Fι	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 3 □ Midowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	
2-003e	within 72 hours after death with the Maryland one. Than "natural", or Itams 23e or 28a-f show the Medical Examiner must be notified at		15. Decedent's Education 16a. Dece	edent's Usual Occupation	1	16b. Kind of Business	11 te /Industry
<u>.</u>	nin 72 ni "ni Medii	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of wor DO NOT use retired)	rking		,
7	giene giene er tha	mo:	Elementary/Secondary (0-12) College (1-4or 5+) Traff	ic Engineer		C&P Teleph	ione
/land	be file ital Hy id oth avant	Be (17. Father's Name (First, Middle, Last) John Searles Boulden, Sr.	18. Mother's Nan Elizabet	ne (First, Middle, M		
<u> </u>	Meniarke narke	To					
<u>a</u>	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar adment of Health and Marylar death of Health Hygienal Hygienal or adment 23e or 28e-f show ortant: I fam 27 is marked other than "natural", or liams 23e or 28e-f show injury or other traumatic avent, the Medical Examinations to the rolling at injury or other traumatic avent, the Medical Examinations to the rolling at 8.			ing Address (Street and Number or Ru		•	
a)	1 and Heali tam 2		Elizabeth H. Monaghan /daughter 2203 20a. Method of Disposition 20b. Place of Disp	osition (Name of		UIII,MD ZIU	
2	Pages nent of int: If it iry or o			ervice Corp. 5/9	/05 T	Towson, MD	
baltimor	permit. Pages Department of Important: If i any injury or o		. 200	2. Name and Address of Facility		1050 York	Road
ñ	permi Depa Impo any id		Peter Clay	uck Towson Funeral	1 Home	Towson, N	
г			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	INFAUTION			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	A			etr o 1
	Lxammer	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	ATHEROGENESU			20 yu.
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(iA)			20 41
,	be executed ician and burial-transit	Examiner	resulting in death) Last C. Type Consequence of):	(Y)			7 C 4.14
09/	0 2 0	cal	Co TYRE 2 DI	BETH MEUT	Cy		2040
200	leath certificat attending phy I for use as th	Medi	IF FEMALE:				
X Q	death ce e attendi ad for use	Physiclan/Med	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of de Month	livery Day Year
	the dea by the a ached fo	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			,
Ţ.	w requires that the death been signed by the atte should be detached for		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
SD	requires that een signed b nould be deta	d by	PLADECTURION		1 🗆 Yes	s 2 No 3 P	robably 4 Honknown
Hecord	taw req as beer 2 shou	ompleted	(ACDIOMU OPATHU		24a. Was an	24b. Were a	utopsy findings available
Ž	9 4 9	omi			autopsy perform 1 Yes 2	ed? death?	completion of cause of
Vital	ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one		
O TO	S 0 10	To	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		lome 5 Resider	nce 6 Other (Spe	cify)
	ding Phy. h. After thi funeral	on:	27. Manner of Death 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	w injury occurred	
DIVISION	Attanding in death. sctor: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined	M 1 Yes 2 No	28f Location (Stro	eet and Number or R	ural Route Number
2	- 0 -	Certification:	4 Homicide determined building, etc. (Specify)	rest, factory, office	City or Town,		arai riodio rvamber,
	ispitel or nours afte naral Dir / filled in	alc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	, and due to the car	use(s) and manner as	s stated.
	To the Hospitel o within 24 hours aff To the Funaral Di completely filled in	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
	To the to the comp	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Mont	
	T	(James J. James IN	D 000362	31 1	100 YAL	AUUS
2	0+1		30. Name and address of person who completed cause of death (Item 23a) (Type		3 ATTIMONE	, MAMIN	n 21204
9	Sta	to	31. Date filed (Month, Day, Year)			, wheelow	7
*-	Registr		and a count for	harle			
		100	MIDVEL M. CLILL A.				

			1 - For State of Maryland / Dep	partment of Health and Nertificate of Death		ene g. No. 2 11 11	
	Physic /Medi	cal	Calul A.	Brown	2. Date of Death Month May	Day 4 2005	
	Examir Funeral Director	ner	North Arundel Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	4b. City, Town, or Location of Death Glen Burnie If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. B	ath Arundel irthplace (State or Foreign Country)
	· ·	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		May 7,19	33 (10d. Inside City Limits
	ath with the s 23a or 28a-	rai Director	10e. Street and Number 404 Norman Avenue	10f. Zip Code 21060		g. Citizen of What C	Country?
9036	72 hours after death with the Maryland naturel', or items 23a or 28a-f show disal Examinat must be notified at	d by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	within ene. then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Dece (Give life.) 16b. Decedent's Education (Give life.) Ho	edent's Usual Occupation a kind of work done during most of work DO NOT use retired) omemaker	ing 16	Own Home	,
Maryland	2 should be filed and Mental Hygin is marked other aumatic event,	To Be (17. Father's Name (First, Middle, Last) John Irwin McLaughlin		e (First, Middle, Ma	Laughlin	Tin Code)
	1 and 1ealth sm 27 ther tr		Mr. Edward J. Brown / husband 404 20a. Method of Disposition 1 Burial 2 Cremation 3 Memoral from State	Norman Avenue, Gle osition (Name of matory or other place)	n Burnie	MD 2106 c. Location - City or	O Town, State
Baltimore,	permit. Pages Department of H Importent: if ite eny injury or of		21. Signature of Funeral Service Licensee 2. Wash Co. Vanuuru Mol35-7 1	ley Cemetery May 9 2. Name and Address of Facility Sin Second Avenue S.W	gleton Fu ., Glen B	ineral Hor Burnie, M	me P.A.
To the last of the	Physician /Medical Examiner	Examiner	23a. Part1. Enset be disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	ter the mode of dying, such as cardiac of your carelial Gastric	Total Cav	Partio	Approximate Interval Between Onset and Death 10 My
Box 68760,	leath certificate be executed attending physician and for use as the burial-transit	ician/Medical Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy		23d. Date of del	
ls, P.O.	res that the de igned by the a be detached t	hys	1 Yes 22 No 4 Pregnant at time of death 5 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the unit of the significant conditions.	Other (specify)	23e. Did tobac		Day Year the cause of death?
Record	has been s ge 2 should	Completed			1 Yes 24a. Was an autopsy performed 1 Yes 2	24b. Were au	topsy findings available completion of cause of
	or Attending Physician: ter death. irector: After this certific n by the funeral director.	Certification; To Be C	25. Was case referred to medical examiner? 1 Yes 2 (2No	28c. Injury at 2 Work? M 1 \(\text{Yes} \) 2 \(\text{No} \)	(Check only one) ne 5 Residence 8d. Describe how in	e 6 Other (Specification)	cify)
_	Hospi 4 hou Funer ely fill	edical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death one in the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and restigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
1	To the within 2 To the complete	Σ	30. Name and address of person who completed cause of death (Item 23a) (Type, I	29c. License number D 3904	/ 29d.	Date signed (Month	6 2005
5	Stat Registra		31. Date filed (Month, Day, Year) MAY 0 9 2005	50% Tos	umie	Driving	5 2106/

			1 - For State Registrar	Sta	ate of Maryla		rtment of H tificate of I			ene 1. No	
	Dhusia	20	Decedent's Name (First)	, Middle, Last)					2. Date of Death	20 U	3. Time of Death
	Physici /Medi		JULIA		OTHOFF				APril 2	9'200	5 805 PM
	Examir Funeral Director	ier	4a. Facility Name (If not in 5. Social Security Number 215-05-547	- Keedy	7. Age (Inty	rs. last birthday) Yrs.	4b. City, Town, or Portion If Under 1 Year Months Days	Location of Death SOCO If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	4c. County of De VAS 9. B	ath 1970 irthplace (State or Foreign Sountry) ARYLAND
			Usual Residence of Deced	dent		6:t. T			0011 4	, 1 J 1 4 P12	
	death with the Maryland me 23s or 28e-f show	ō	MD.	County		City, Town or Lo					10d. Inside City Limits 1 X Yes 2 ☐ No
	the N	rect	10e. Street and Number	N/A		BALTIM	JRE 10f. Zip Code		100	J. Citizen of What (
	th with 23a or	ai Di	336 S. E	BOULDIN :	STREET		2.	1224		U.S.A.	
920	after or its	by Funeral Director	11. Marital Status 1 Never Married 2 3 WWidowed 4 Di	☐ Married 1 [as Decedent Ever in med Forces? Yes 2 No Yes, Give ar or Dates:	4	/as Decedent of Hi Yes, specify Cubar ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	rerican Indian,
5-0036	72 hours "natural",	eted	15. Do	ecedent's Education highest grade com	pleted)	16a. Deced	ent's Usual Occupa	ition	ing 16	b. Kind of Busines	
2121		Completed	Elementary/Secondary (oltege (1-4or 5+)	life. E	O NOT use retired,)	rg		
d 2	Hygie Hygie other ent. II		17. Father's Name (First, A	Middle, Last)		HOU	SEWIFE	18. Mother's Nam	e (First, Middle, Ma	DOMESTI	.C
ılan	uld be Mental rrked c	To Be	JOHN FRO	NCKOWIA	Κ			JOSE	PHINE 2	IEMKOWS	K.L
Maryland	ges 1 and 2 should be filed withir it of Health and Mental Hygiene. If Item 27 Is marked other then or other treumatic event. It a M.		19a. Informant's Name/Re		•	19b. Mailin	Address (Street a		al Route Number, C		
	1 and Health Bm 27 ther to		MARIE BAUT 20a. Method of Disposition			340 S Place of Dispos	SUNBROOK		HAGERSTC		
Baltimore,	ages ant of little it: If Its y or o		1√ Burial 2 □ Crem '4 □ Donation 5 □ O	nation 3 🗌 Remova	al from State	cemetery, crem	atory or other place	e)		c. Location - City o	
altir	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral		11	EW CATE	Name and Addres	s of Facility	7 5/5/05	BALTIM	ORE, MD.
ä	Depa Impo any ir		1 dente	180	There		OU S. CON	IKLING S	INC. FUN	ALTIMOR	ME E.MD. 21224
1			23a. Part1. Enter the dise shock, or heart failur	ase, or complication e. List only one cau	s that caused the de se on each line.	ath. Do not ente	r the mode of dying	, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a. C		e Hear	7 Farly	ح			Years
	Examiner				Due to @ as a cons	equence of):	,				UR DES
	P ≅	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s, te	Due to (or as a con-	uence of):					0
	ificate be executed g physician and as the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to for as a cons	min					year.
68760,	sician buria	ia E			Due t *(or as a cons	equence or).					
687	None Prop. or	edicai		d							
O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 □ Yes 2 No 9 □ Unknown	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/es, outcome of preg □Live birth 2 □ Fe □ Pregnant at time o □ Unknown	ital déath 3 □I	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
G,	res that signed b	by PI	Part II. Other significant c			esulting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ord	w require been sig should b	ted	Gastrointe	stice l	sleed				1 🗆 Yes	2□No 3□F	robably 4 Mnknown
of Vital Records,	sicien: The law r s certificate has be lirector, page 2 sh	Completed	cellulin's		lin resign	nt sta	ph away	<u> </u>	24a. Was an autopsy performed	24b. Were a prior to death?	utopsy findings available completion of cause of s
V.	sicier s certif	To Be	25. Was case referred to n examiner? 1 Yes 2 No	nedical Hospita	il: 1 🗌 Inpatient 2	□ EP/Outpationt			Check onl one	2.70	
	ding Physicien: h. After this certific funeral director.		27. Manner of Death		Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at Nursing Ho	me 5 Residenc 28d. Describe how		ecity)
Division	andin eath. or: Af the fur	Certification:	2 Accident	Pending investigation	(menun, bay rour)	injury		es 2 No			
ΞĚ	after death Director: in by the	artifi		Could not be determined 28e	. Place of Injury · At building, etc. (Spe	home, farm, stre	et, fectory, office		28f. Location (Stree City or Town, S	t and Number or Fi State)	tural Route Number,
	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funerel Director: After this certification of the Funerel Director. completely filled in by the funeral director.	edicai Ce	29a. Certifier 1 Co (Check only 2 Me	artifying Physician: adical Examiner: Or an	To the best of my k n the basis of exami nd manner stated.	nowledge, death nation and/or inve	occurred at the time estigation, in my opi	a, date and place, nion, death occurr	and due to the caus ed at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the To the Comp	M	29b. Signature and title of				29c. License		29d.	Date signed (Mon	th, Day, Year)
	×		Have Vas				,p002	7600	4/	30/05	
10	0		30. Name and address of p	Ross BU				7.22		90	
W		- 1	4 4 1 1 1 1 March 1 3				2111	1 44 4			
	Sta	te	31. Date filed (Month, Day,		2. Registrar's Sig	hs haz	ND Z	1783			

	20	Decedent's Name (First, Middle, La.		- 41	_				2. Date of De Month		Yane	Year	3. Time of Death
Physicia /Medic			Mary Heler	Butle	r				At	oril 27	, 2005		Unknown M
Examin		4a. Facility Name (If not institution, give			4b. City	, Town, or	Location		ott City	40	. County		ward
Funeral		5. Social Security Number 6. S	8700 Ridge Rd. ex / 7. Age (In	yrs. last birthda		r 1 Year		24 Hrs.	8. Date of Bir	rth		9. Birth	place (State or Foreign
oirector			□M 2XF	72 Yrs.	Months	Days	Hours	Min.	(Month, Da February			Cou	Maryland
302	-		100	. City. Town or	Location								10d. Inside City Limits
a-f sho	ctor					Ell	licott C	ity					1 □ Yes 2 No
Sa or 28 Lbe.no	i Dire	10e. Street and Number			10f. Z	ip Code	21	043		10g. Ci	tizen of V	Vhat Cou U.S	
ms 2:	era	8700 Ridge Rd.	12. Was Decedent Ever	in U.S. 1	3. Was Deci	edent of Hi	ispanic Or	igin? (Sp	ecify Yes or No)-			
l', or iter	by Fur	1 Never Married 2 Married 3 Novidowed 4 Divorced	1 ☐ Yes 2 🔼 No If Yes, Give			10			Hican, etc.)				, etc. White
atura Cal E	ed	15. Decedent's E	ducation	16a. De	cedent's Us	ual Occupa	ation			16b. F	(ind of Bu	siness/Ir	ndustry
e. Mari	piet	(Specify only highest gra Elementary/Secondary (0-12)	completed) Cotlege (1-4or 5+)	(G life	ive kind of w e. DO NOT	use retirea	1)		ing			Food	Service
ygien ner th t, the	Co	6				Cafete							
e de at	Be						18. Moth	er's Name			_	-	
mar umat	-			19b. Ma								State, Zi	p Code)
alth a 127 la ertra		Mr. Pobort P Rutler	Sr Son		7921 F	Red Bai	rn Way	Elkrid	ge, Maryla	and 21	1075		
of He fitern rothe		20a. Metriod of Disposition	Removal from State	Ob. Ptace of Discemetery, of	sposition (Na crematory or	ame of other plac	:е)			20c. L			
ant: l				Crest L	awn Me	morial (Garden	s 05	6/02/2005		Marr	iottsvii	e, Maryland
Depart Import any Inj		21. Signature of Funeral Septice/Lice	nse Kall	11293	22. Name a	Slack	Funera	al Hom	e, P.A.	ott Cit	v. MD	21043	3
-		23a. Part1. Enter the disease, or com	plications that caused the	death. Do not	enter the mo						.,,		Approximate Interval Between
vsician		Immediate Cause (Final		ARE	AR	1012	ا در ا	SEX	HE				Onset and Death
Medical		resulting in death)	Due to (or as a co	nsequence of):					13				10112
aminer		Sequentially list conditions.	b. HYPER	L FURS 2	LON								<u>.</u>
sit	ine	if any, leading to immediate	Due to (or as a co	nsequence of):									
and II-tran	хап	that initiated events resulting in death) Last	C. Due to (or as a co	nsequence of):									
sicien buria	ai	(d										
g phy as the	edic		u										
endin use	M/u	IF FEMALE: 23b. Was decedent pregnant			3 □Ectopic	oreonancy	,						*
the att	sicia	1 □ Yes 2 □ No									Mo	nth	Day Year
ad by	Phy		contributing to death but no	t resulting in th	e underlying	cause give	en in Part	I.	23e. Did	tobacco	use conti	ribute to 1	the cause of death?
E 0	d by		•						1 🗆	Yes 2	□No	3 Pro	bably 4 DUnknown
shoul	ete								24a Was	an	24b. \	Nere auto	opsy findings available
has Je 2	ошо								auto perfe	psy ormed?		prior to co leath?	emptetion of cause of
tificat lor. pa	e	25. Was case referred to medical					26. Plac	e of Deat			o '	□ Tes	2L No
is cer direct	00	examiner?	Hospital:	2 ER/Outpa	itient 3 0	Oth	oc				6 □Oth	er (Speci	fy)
ter th	L:uc	27. Manner of Death	28a. Date of Injury (Month, Day Yea			28c. Injun Worl				-			
er: Af	satic	2 Accident investigation			М			No No					
= F te	ertific	4 Homicide	289. Place of Injury -	At home, farm, pecify)	, street, facto	ory, office			28f. Location (City or To	Street a. wn, Stat	nd Numb e)	er or Run	al Route Number,
4 hours -unerel	ical C	(Check only 2 Medical Exa	miner: On the basis of exa	mination and/o	eath occurre	d at the tin	ne, date a	nd place, ath occur	and due to the	cause(s	and ma	nner as s	stated.
the I	Med	one)	and manner stated.										
L CO T WILL		255. Signature and title of certains	and a Ma		15	ALPI Y	(0)			AP	211	289	F) 2005
1		30 Name and address of parent with	completed cause of death	(Item 23a) /T	ne Print\	000	315	70	V1751.	0		-0	رت س
(Should all address of person who	Caul 7 A C	650	5AN71	AGG	Ro	41)	, Coi	UN	BIA	MU	21045-
Sta	ate	31. Date filed (Month. Day, Xear)	32. Registrars	Signatura	2					-			
	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and projectly filled in by the funeral director, page 2 should be detached for use as the burial-transit program on the funeral director. To the funeral director, page 2 should be detached for use as the burial-transit program on the funeral director.	Iter death. The death. The death. The death. The death and Mental Hygiene. The death and Hygiene. The death and Mental	Usual Residence of Decedent 10a. State 10b. County Maryland 10b. County	Usual Nessidence of Decedent 10a. State 10b. County 10c	Usual Fleedance of Decedent 10a. State 10b. County 10c. City, Town or 10a. Decedent 10a. State 10b. County 10c. City, Town or 10a. Decedent 10a. State 10b. County 10c. City, Town or 10a. Decedent 10a. State 10b. County 10c. City, Town or 10a. Decedent 10a. State 10b. County 10c. City, Town or 10a. Decedent Usual Field of the County 10c. City, Town or Location 10c. Stripet and Number 10f. 2 10c. City, Town or Location 10c. Stripet and Number 10f. 2 10f. 2 10c. Stripet and Number 10f. 2 Usual Fallowing Ande	Usual Table Date 10b. County 10c. City, Town or Location Ellicott C	Usuar Missouries of December 10c. City, Town or Location 10c. City 10c. City, Town or Location 10c. City Usual Telephotic of Decided 10b. County 10c. City, Town or Location 10b. State and Number 10b. County 10b. State and Number 10b. State a	Use The County Use Description of the property	Description of Property of the Control of the Co				

				partment of Health and	•	•	
		1 - For State Registrar		ertificate of Death		. No. 2005	151,98
Physic	ian	1. Decedent's Name (First, Middle, Last)	Τ		2. Date of Death Month	Day Year	3. Time of Death
/Med	ical	William	Booze	1 0 T	MAY	02 3005	5 A M
Exami	iner	4a. Facility Name (If not institution, give st 101 LEONARD CT	reet and number)	4b. City, Town, or Location of De	ath	4c. County of Death	DET
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho			ANNE ARUN	DEL ace (State or Foreign ry)
Director		216 - 32 - 0434 14 Usual Residence of Decedent	M 2□F 69 Yrs	Months Days Hours Mi	n. (Month, Day, Y	35 M	
e Marylan 8a-f show	Director	10a. State 10b. County Anne Ar	under Gler			10	d. Inside City Limits 1 Yes 2 No
th with the	ai Dire	10. Street and Number	'Court	10f. Zip Code 21060	10g	G. Citizen of What Country US A	ry?
215-0036 thin 72 hours after death with the Maryland e. an "natural; or Items 23e or 28e-f show Medical Evanirer must be redified at	by Funerai	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes TN If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 Yes 2 No Specify: 1 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, et Specify: Wh	
i 2 2 2	Completed	15. Decedent's Educi (Specify only highest grade	completed) (G	ocedent's Usual Occupation live kind of work done during most of w e. DO NOT use retired)	vorking 16	6b. Kind of Business/Indu	ıstry
Marit and Marie and Marie and Marie and Marie and Marit and Marie	Com	Elementary/Secondary (0-12)	College (1-4or 5+) W	estinghouse		TECHNOI	LOGY
ind 2 be filad hal Hygi d other event, L	Be	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Ma		
Maryland d 2 should be fila th and Mental Hy 27 is marked oth traumetic event	2	JOHN WILLIAM BOOZE 19a. Informant's Name/Relationship (Typ.	o Oriot) 10h M	RUTH BO			
		SHIRLEY BOOZE		ailing Address (Street and Number or I LEONARD CT GLEN			20de)
or other tra		20a. Method of Disposition	20b. Place of Di	sposition (Name of crematory or other place)	_	c. Location - City or Tow	n, State
Pages ment of ent: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	BAYVIEW		.2005 F	BALTIMORE, N	4D
Baltimore, permit. Pages 1 at Department of Hea Importent: If item any Injury or othe once.		21. Signovice of Funeral Service Livense (REGORY XIN)	1	FINK FUNERAL HOMI 426 CRAIN HWY SW		E. MD 21061	
Pn ysicia n /Medical	_	23a. Part1 Enter the disease, or complic shock or heart failure. Jist only one Immediate Cabse (Final disease or condition resulting in death)	cause on each line.		ac or respiratory arrest	i.	Approximate Interval Between Onset and Death
760, Ite be executed was in a partial and purial-transit	Ical Examiner	Sequentially list conditions, fary, each of the massage cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of):				
O. Box 68 the death certifica y the attending ph iched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month D	/ Day Year
ds, Puires that signed build be detailed	by	Part II. Other significant conditions contribute the Per Hens 10 r		e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
	Completed	hypercholes	Golemia)		24a. Was an autopsy performed	prior to comp	sy findings available pletion of cause of
Vital F sicien: Th certificate	Be	25. Was case referred to medical examiner?			eath Check onl one		
Phy rald	on; To	1 Pes 2 No 27. Manner of Death 1 Natural 5 Pending	spital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Time Injur	of 28c. Injury at	Home 5 Residence 28d. Describe how	e 6 Other (Specify)	
Si ten ten tor:	ertification;	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	206 Looption (Ctro-		2
in the part of the	0	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, S		
Me Hospital	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowledge, depr: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as state and place, and due to the	ed. ne cause(s)
To the I within 2 To the I complet	Me	29b. Signature and title of certifier				Date signed (Month, Da	ıy, Year)
		1 Janey a	Sauson 1	10 D31586	A	1ay 2, 2	005
4		30. Name/and address of person who com	NSON MD		est T	Balhmo	10 21201 10 MD
St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 0 9 2005	37 Registrar's Signature	orle			

	1 - For State Registrar	State of Maryland	Department of Health an Certificate of Death		giene 2005	15499
Physician /Medica		B	Conaway	2. Date of Dea	Day Year 2005	3. Time of Death
Examiner Funeral Director	4a. Fecility Name (If not institution, give Renaissance Gare 5. Social Security Number 6. Se 222-10-7622 15. Usual Residence of Decedent 10a. State 10b. County	dens x 7. Age (In yrs. last dens 2	birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	1918 Will.	place (State or Foreign only) DE iamsville
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or itama 23a or 28a-1 show any injury or other traumatic event, the Mudical Examinar must be notified at once.	3148 Gracefiel 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grad) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	Rd Apt. 406 12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 Yes 2 No Specify: 6a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Teacher/Superv 18. Mother's 19b. Mailing Address (Street and Number of Disposition (Name of other), crematory or other place) urrection Cem. 5 22. Name and Address of Facility	? (Specify Yes or No- ruento Rican, etc.) f working VISOT Name (First, Middle, or Rural Route Numbe	Black, White, Specify: Black Black Black, White, Specify: Black Black, White, Specify: Blac	can Indian, etc. ack dustry col col code) MI48823 own, State
so that the death certificate be executed es that the death certificate be executed gned by the attending physician and be detached for use as the burial-transit	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate that Indexlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	a. Metastatic Due to (or as a consequen b. Due to (or as a consequen c. Due to (or as a consequen d. Due to (or as a consequen d. Pregnant at time of deatt 9 Unknown	ce of): ce of): ath 3 □Ectopic pregnancy	23e. Did to	23d. Date of delive Month Displaced use contribute to the second	Day Year the cause of death? bably
Ital or Attending Physician: Its after death. Tal Director: After this certification by the funeral director.	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) ysicien: To the best of my knowle liner: On the basis of examination and manner stated. Multiple of the state of the	/Outpatient 3 DOA Other: 4 Nursi b. Time of Injury Mork? M 1 Yes 2 No o, farm, street, factory, office dge, death occurred at the time, date and pand/or investigation, in my opinion, death 29c. License number MD D 59521	1 ☐ Yes Death (Check only of the condition of the condit	prior to code death? 2	al Route Number, stated. o the cause(s)
State Registra	31. Date filed (Month, Day, Year)	MANA, 3110 GR. 32. Begistrar's Signature	ACEFIELD ROAD, S	ILVER SPA	RING, MD	20904

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year oway err 2005 7 40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore The Johns Hopkins Baltimore City Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Director 220-66-7463 48 MD 10/23/1956 Usual Residence of Decedent with the Maryland 10a. State 10b. County ir than "neturel", or Items 23s or 28e-f show The Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No BALTIMORE MD HALETHORPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 808 RAMBO COURT filed within 72 hours after death 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ WHITE Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME treumetic event. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any lipiry or other treumetic event 9DR8. Be 18. Mother's Name (First, Middle, Maiden Sumame) JAMES HATCHER CARPENTER MARY ELLEN BERKERIDGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. ROBERT COWAN / HUSBAND 808 RAMBO COURT, HALETHORPE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 05/08/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA World 1 SECOND AVENUE SW, GLEN BURNIE, MD MO1415 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Infacction /Medical Due to (or as a consequence of): Examiner Gastric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cancer Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclan an/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 nonths? Month Dav Year by Physici 4☐Pregnant at time of death Yes 5 Other (specify) the detached 9 Unknown 9 Unkr been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2500 28 No 1 Yes 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) (his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury Natural М 1 Yes 2 No 2 Accident investigation Director; in by the 6 Could not be determined 3 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To the Funerel [medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) May MO RES - 000 Giannak E04 105:4 lina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe Street Baltimore MD21287-9106 No Rth Giannakikou 600 inac Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 9 2005 Registrar